CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391			
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	A. BUILDING 00			COMPLETED	
		15G447	B. WING 01/21/2015				/2015	
			B. WINC		ADDRESS SITU STATE TIP SODE	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE			
					NOLLTON RD			
VOCA CO	ORPORATION OF	INDIANA		INDIAN	IAPOLIS, IN 46228			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	.16	DATE	
W000000								
	This visit was fo	or a post-certification	woo	00000				
		•	""	,0000				
	` ′	rvey to the recertification						
	and state licens	ure survey completed on						
	11/12/14.							
	This visit was in	n conjunction with the						
		complaint #IN00162396.						
	investigation of	complaint #1100102390.						
	Survey dates: J	anuary 13, 14, 15 and 21,						
	2015							
	Facility Numbe	r: 000961						
	_							
	Provider Numb							
	AIM Number:	100244750						
	Surveyor:							
	Paula Eastmone	1. OIDP-TC						
		.,						
	ть 1. С.:	: 1						
		ies also reflect state						
	_	ordance with 460 IAC 9.						
		impleted 1/27/15 by Ruth						
	Shackelford, QIDI).						
144000400	400 440							
W000102	483.410	DDY AND MANAGEMENT						
	_	ensure that specific						
	governing body a requirements are							
	•		WOO	00102	CORRECTION: The facility		02/20/2015	
		vation, interview and	I woo	00102	must ensure that specific		02/20/2015	
	-	the facility failed to meet			governing body and managen	nent		
	the Condition o	f Participation:			requirements are met.	.5.11		
	Governing Bod	y for 2 of 4 sampled			Specifically, the governing boo	dv		
		C) and for 1 additional			has facilitated the following:	,		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILDING	00	COMPLETED
		15G447	A. BUILDING B. WING		01/21/2015
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	R		(NOLLTON RD	
VOCA C	ORPORATION OF	ΙΝΠΙΔΝΔ		NAPOLIS, IN 46228	
	1			VAI OLIO, IIV 40220	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	· ·	DATE
		governing body failed to		The investigation into Client F discovered injury on 11/5/14 I	
		ty did not neglect client		been located.	ias
	C, conducted the	orough investigations in		The Residential Manager	
	regard to neglec	t and/or injuries of		responsible for failing to comple	ete
	unknown source	for clients B, C and H,		thorough investigations of Clien	
	and to ensure co	rrective measures/actions		C's falls and Client B, C and H's	
		otect client C from falls.		injuries of unknown origin has	
	Were taken to pr	oteet enem e nom runs.		been removed from the facility	
	Findings include			and no longer serves in a forma	ıl
	rindings include	.		supervisory capacity.	
				ADDENDUM 2/17/15: The	
1. The governing body failed to ensure			Operations Team, including		
	the facility met the Condition of			the Program Manager and	.
	Participation: C	lient Protections for 2 of		QIDP, will directly oversee a investigations. The	111
	4 sampled client	s (B and C) and for 1		Residential Manager will	
	additional client	(H). The governing		receive additional training	
	body failed to er	sure the facility		toward assisting with	
	-	written policy and		gathering evidence, includir	ng
	^	event neglect of client C		conducting thorough witnes	ss
		The governing body		interviews. The Clinical	
	_	the facility conducted		Supervisor and Program	
				Manager will assure that	
		gations in regard to all		conclusions are developed	
	_	ouse, neglect and/or		that match the collected	du
	"	own source for clients B,		evidence. The governing Bowill assume complete	uy
		overning body failed to		responsibility for	
	ensure the facilit	ty developed corrective		investigating any discovered	. l
	actions/measure	s for client C in regard to		injuries that require outside	
	falls which occu	rred in the bathroom.		medical treatment. When ar	I
	Please see W122	2.		evidence of staff negligence	1
				is uncovered or alleged the	
	2. The governing	ng body failed to ensure		Operations Team will take	
	_	emented its written policy		control of all aspects of the	
	, ,	1 2		investigation process.	
	•	to prevent neglect of the			
		to falls in the bathroom to			
	prevent potentia	l falls and injuries for			

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
VOCA CORPORATION OF INDIANA 4114 KNOLLTON RD INDIANAPOLIS, IN 46228	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY	(X5) COMPLETION DATE
elient C. The governing body failed to ensure the facility implemented its written policy and procedures to conduct thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source for clients B, C and H, and to ensure corrective measures were put in place for client C in regard to monitoring and supervision. The governing body failed to ensure the facility conducted thorough investigations in regard to allegations of possible neglect and/or injuries of unknown source for clients B, C and H. The governing body failed to ensure the facility put in place corrective measures to prevent client C from falling in the bathroom. Please see W104. 9-3-1(a) Client C has begun receiving twice weekly physical therapy sessions and a daily home exercise program has been initiated to enhance Client C's core strength to diminish the incidence of falls such as occurred on 12/12/14 and 12/15/14. An Occupational Therapy evaluation has been scheduled for Client C to evaluate the effectiveness of current adaptive equipment and to obtain recommendations for enhancements. In the intertin, after appropriate due process, the team will provide the following adaptive modifications: the seat belt will be re-fitted to Client C's wheelchair and a chair alarm will be installed to alert staff when the seat belt has become unfastened. Client C will receive enhanced provide a modified toilet seat with side rails. The nurse will modify Client C's corprehensive High Risk Plan for falls to clarify the expectations for "stand by" assistance while lient C is in the bathroom including but not limited to hands on use of a galt belt at all time while elient C is	

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/21/2015
	ROVIDER OR SUPPLIER		4114 K	ADDRESS, CITY, STATE, ZIP COD NOLLTON RD	DE
VOCA CO	DRPORATION OF	INDIANA	INDIAN	IAPOLIS, IN 46228	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION (X5) ILD BE COMPLETION ROPRIATE DATE
				toileting and showering.	
				PREVENTION:	
				ADDENDUM 2/17/15: A tracking spreadsheet fo incidents requiring investigation, follow-up corrective/protective measures will be maintand distributed daily to facility supervisors and Operations Team. The C Supervisor (Administrat level management) will with his/her facility management teams we to review the progress on all investigations that open for their homes. Residential Managers we required to attend and so an in-service at these meetings stating that the are aware of which investigations with which they are required to assemble well as the specific components of the investigation for which investigation for which	and ained the Clinical tive meet ekly made at are vill be sign ney ch
				are responsible, within a five business day timefrom the Clinical Supervisor of the Clinical Superviso	rame. will on to

	T OF DEFICIENCIES DF CORRECTION	IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 01/21/2015
NAME OF P	ROVIDER OR SUPPLIEF	<u> </u>		ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD	
VOCA CO	ORPORATION OF	INDIANA		IAPOLIS, IN 46228	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	designate an investigation, completed, if it does not me these criteria. The Program Manager will also conduct spot checks of investigation focusing on serious inciden that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thoroug investigations within the allowable five business day timeframe will result in progressive corrective actional applicable team members. The Residential Manager will develop and maintain a staffi matrix that assures adequate direct support staff who possible training, skills and capable to provide appropriate active treatment and assure the heal and safety of clients at all time. Members of the Operations and documentation reviews no lethan five times weekly for the 21 days, no less than 3 times weekly for an additional 14 December 14 days, no less than 14 december 15 days, no less than 3 times weekly for an additional 14 December 16 days, and less than twice weekly an additional 60 Days. At the	as set as, ts Il ng ess silities alth nes. Feam stive ss e next says, y for
				conclusion of this period of intensive administrative	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		15G447				01/21/	2015
			B. WIN		DDDECC CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD		
VOCA CO	ORPORATION OF I	NDIANA			APOLIS, IN 46228		
VOCACC	DRECKATION OF I	INDIANA		INDIAN	AFOLIS, IN 40228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Administrative support at the home will focus on mentorship and training of supervisory stamonitoring and coaching of dir support staff, and evaluation of the effectiveness of current risplans and safety protocols. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Operations Team	off, ect f k	
W000104	policy, budget, and the facility. Based on observer record review for (B and C) and for the governing borgeneral policy are over the facility of not neglect client investigations in injuries of unknown C and H, and to emeasures/actions client C from fall. Findings include	dy must exercise general doperating direction over ation, interview and r 2 of 4 sampled clients r 1 additional client (H), but failed to exercise and operating direction to ensure the facility did t C, conducted thorough regard to neglect and/or own source for clients B, ensure corrective is were taken to protect ls.	W00	00104	CORRECTION: The governing body must exercise general policy, budget, and operating direction over the facility. Specifically, the governing bodhas facilitated the following: The investigation into Client Hidiscovered injury on 11/5/14 hidiscovered	dy 's as	02/20/2015
	general policy ar	ng body failed to exercise and operating direction to ensure the facility			Operations Team, including the Program Manager and QIDP, will directly oversee al	II	

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Event ID:

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Facility ID: 000961

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			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G447	B. WIN	IG		01/21/2015
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					NOLLTON RD	
VOCA C	ORPORATION OF I	NDIANA		INDIAN	APOLIS, IN 46228	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		written policy and			investigations. The	
	procedures to pro	event neglect of the			Residential Manager will	
	client in regard t	o falls in the bathroom to			receive additional training toward assisting with	
	prevent potential	falls and injuries for			gathering evidence, including	.
	client C. The go	verning body failed to			conducting thorough witness	
		policy and operating			interviews. The Clinical	
		e facility to ensure the			Supervisor and Program	
		nted its written policy			Manager will assure that	
	1 - 1	o conduct thorough			conclusions are developed	
		regard to allegations of			that match the collected	
		C C			evidence. The governing Bod	У
abuse, neglect and/or injuries of unknown source for clients B, C and H, and to				will assume complete responsibility for		
				investigating any discovered		
		e measures were put in			injuries that require outside	
	_	C in regard to monitoring			medical treatment. When an	v
	and supervision.	Please see W149.			evidence of staff negligence	
					is uncovered or alleged the	
	2. The governin	g body failed to exercise			Operations Team will take	
	general policy ar	nd operating direction			control of all aspects of the	
	over the facility	to ensure the facility			investigation process.	
	conducted thoro	ugh investigations in				
	regard to allegati	ons of possible neglect				
	and/or injuries of	f unknown source for				
	clients B, C and	H. Please see W154.				
	ĺ				Client C has begun receiving	
	3. The governin	g body failed to exercise			twice weekly physical therapy	
		nd operating direction			sessions and a daily home exercise program has been	
	1	to put in place corrective			initiated to enhance Client C's	
		rent client C from falling			core strength to diminish the	
	_	Please see W157.			incidence of falls such as	
	in the bathloom.	TICASC SCC WIJ/.			occurred on 12/12/14 and	
	0.2.1(a)				12/15/14. An Occupational	
	9-3-1(a)				Therapy evaluation has been	
					scheduled for Client C to evaluate	е
					the effectiveness of current	_
					adaptive equipment and to obtai	"

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/21/2015
	ROVIDER OR SUPPLIER DRPORATION OF INDIANA	4114 K	ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD IAPOLIS, IN 46228	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
			recommendations for enhancements. In the interim, after appropriate due process, the team will provide the following adaptive modifications the seat belt will be re-fitted to Client C's wheelchair and a chai alarm will be installed to alert staff when the seat belt has become unfastened. Client C wireceive enhanced supervision—line of sight observation and 1 minute checks while in her bedroom. A bed alarm and aud monitor will be placed in her bedroom. The team will also provide a modified toilet seat with side rails. The nurse will modify Client C's Comprehensiv High Risk Plan for falls to clarify the expectations for "stand by" assistance while Client C is in the bathroom including but not limited to hands on use of a gai belt at all time while client C is toileting and showering.	ir ill 5 io e /
			PREVENTION: ADDENDUM 2/17/15: A tracking spreadsheet for	
			incidents requiring investigation, follow-up and corrective/protective measures will be maintaine and distributed daily to facility supervisors and the Operations Team. The Clinic	d

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		XI) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/21/2015
	ROVIDER OR SUPPLIER	IDIANA	4114 K	ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD IAPOLIS, IN 46228	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				Supervisor (Administrative level management) will me with his/her facility management teams weekly to review the progress mad on all investigations that ar open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they are thorough —meeting regulatory and operational standards, and will not designate an investigation, completed, if it does not me these criteria. The Program Manager will also conduct spot checks of investigation focusing on serious incident that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorouginvestigations within the	e e e e e e e e e e e e e e e e e e e

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) allowable five business day timeframe will result in progressive corrective action to all applicable team members. The Residential Manager will develop and maintain a staffing matrix that assures adequate direct support staff who possess the training, skills and capabilities to provide appropriate active treatment and assure the health and safety of clients at all times. Members of the Operations Team and the QIDP will conduct active treatment observations and documentation reviews no less than five times weekly for the next 21 days, no less than 5 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Administrative support at the home will focus on mentorship and training of supervisory staff, monitoring and coaching of direct support support of firect supports and coaching of direct support supports of the support of the supports of the support and the home will focus on mentorship and training of supervisory staff, monitoring and coaching of direct supports after the supports of		T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/21/2015
PREFIX 1AG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ### AGE				4114 K	NOLLTON RD	
timeframe will result in progressive corrective action to all applicable team members. The Residential Manager will develop and maintain a staffing matrix that assures adequate direct support staff who possess the training, skills and capabilities to provide appropriate active treatment and assure the health and safety of clients at all times. Members of the Operations Team and the QIDP will conduct active treatment observations and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Administrative support at the home will focus on mentorship and training of supervisory staff, monitoring and coaching of direct support staff, and evaluation of	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
develop and maintain a staffing matrix that assures adequate direct support staff who possess the training, skills and capabilities to provide appropriate active treatment and assure the health and safety of clients at all times. Members of the Operations Team and the QIDP will conduct active treatment observations and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Administrative support at the home will focus on mentorship and training of supervisory staff, monitoring and coaching of direct support staff, and evaluation of					timeframe will result in progressive corrective action to all applicable team	n
the effectiveness of current risk plans and safety protocols. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Operations Team W000122 483.420	W000122	483.420			develop and maintain a staffir matrix that assures adequate direct support staff who posses the training, skills and capabil to provide appropriate active treatment and assure the hea and safety of clients at all time Members of the Operations T and the QIDP will conduct act treatment observations and documentation reviews no less than five times weekly for the 21 days, no less than 3 times weekly for an additional 14 Da and no less than twice weekly an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determithe level of ongoing support needed at the facility. Administrative support at the home will focus on mentorship and training of supervisory staff, and evaluation of the effectiveness of current risplans and safety protocols. RESPONSIBLE PARTIES: QIDP, Residential Manager,	ess ities Ith es. eam ive es next ays, offor ne

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	A. BUILDING COMPLET			ETED
		15G447	B. WIN			01/21/	/2015
					ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹		4114 KI	NOLLTON RD		
	ORPORATION OF				APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	CLIENT PROTEC	ensure that specific client					
	protections require						
	1 -	ration, interview and	$ _{W0}$	00122	CORRECTION: The facility		02/20/2015
		e facility failed to meet			must ensure that specific clien	nt	
		Participation: Client			protections requirements are r		
		2 of 4 sampled clients (B			Specifically: The facility has	i	
		additional client (H).			located the investigation into Client H's discovered injury or	1	
	· · ·	ed to implement its			11/5/14.	•	
	_	nd procedures to prevent			The Residential Manager		
	1 2				responsible for failing to complet	te	
		C in regard to falls. The			thorough investigations of Client		
	facility failed to conduct thorough investigations in regard to all allegations				C's falls and Client B, C and H's		
					injuries of unknown origin has		
	_	t and/or injuries of			been removed from the facility and no longer serves in a formal		
		for clients B, C and H.			supervisory capacity.		
	1	ed to ensure corrective			ADDENDUM 2/17/15: The		
	measures were p	out in place for client C in			Operations Team, including		
	regard to falls w	hich occurred in the			the Program Manager and		
	bathroom.				QIDP, will directly oversee a	II	
					investigations. The		
	Findings include	:			Residential Manager will		
	_				receive additional training toward assisting with		
	1. The facility f	ailed to implement its			gathering evidence, including	a	
	1	nd procedures to prevent			conducting thorough witness	_	
		ient in regard to falls in			interviews. The Clinical		
		prevent potential falls			Supervisor and Program		
		client C. The facility			Manager will assure that		
		ent its written policy and			conclusions are developed		
	procedures to co	2 2			that match the collected	lv,	
	-	regard to allegations of			evidence. The governing Bod will assume complete	ıy	
		•			responsibility for		
	_	nd/or injuries of unknown			investigating any discovered		
		s B, C and H, and to			injuries that require outside		
		e measures were put in			medical treatment. When an	у	
	place for client (C in regard to monitoring			evidence of staff negligence		
	I		1		is uncovered or alleged the		I

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G447	B. WIN			01/21/	2015
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER					
VOCAC		INIDIANIA			NOLLTON RD		
VOCAC	ORPORATION OF	INDIANA		INDIAN	IAPOLIS, IN 46228		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and supervision	. Please see W149.			Operations Team will take		
	•				control of all aspects of the		
	2 The facility:	failed to conduct thorough			investigation process.		
	1	•					
		n regard to allegations of					
	ı ^ ~	t and/or injuries of					
	unknown source	e for clients B, C and H.					
	Please see W15	4.					
					Client C has begun receiving		
	3 The facility	failed to put in place			twice weekly physical therapy		
	1				sessions and a daily home		
		sures to prevent client C			exercise program has been		
		the bathroom. Please see			initiated to enhance Client C's		
	W157.				core strength to diminish the		
					incidence of falls such as		
	9-3-2(a)				occurred on 12/12/14 and		
)				12/15/14. An Occupational		
					Therapy evaluation has been		
					scheduled for Client C to evaluat	e	
					the effectiveness of current		
					adaptive equipment and to obtain	n	
					recommendations for		
					enhancements. In the interim,		
					after appropriate due process,		
					the team will provide the following adaptive modifications		
					the seat belt will be re-fitted to	•	
					Client C's wheelchair and a chair		
					alarm will be installed to alert		
					staff when the seat belt has		
					become unfastened. Client C wil	ı	
					receive enhanced supervision	·	
					-line of sight observation and 15	,	
					minute checks while in her		
					bedroom. A bed alarm and audio	,	
					monitor will be placed in her		
					bedroom. The team will also		
					provide a modified toilet seat		
					with side rails. The nurse will		
					modify Client C's Comprehensive	.	
	I		- 1		1 ,		

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G447	B. WING		01/21/2015
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
\/OOA O		NIDIANIA		NOLLTON RD	
	ORPORATION OF I	NDIANA		APOLIS, IN 46228	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	,	DATE
				High Risk Plan for falls to clarify the expectations for "stand by"	
				assistance while Client C is in the	_
				bathroom including but not	
				limited to hands on use of a gait	
				belt at all time while client C is	
				toileting and showering.	
				PREVENTION:	
				ADDENDUM 2/17/15: A	
				tracking spreadsheet for	
				incidents requiring	
				investigation, follow-up and	
				corrective/protective	
				measures will be maintained and distributed daily to	l l
				facility supervisors and the	
				Operations Team. The Clinical	al
				Supervisor (Administrative	
				level management) will mee	t
				with his/her facility	
				management teams weekly	
				to review the progress made on all investigations that are	
				open for their homes.	
				Residential Managers will be	
				required to attend and sign	
				an in-service at these	
				meetings stating that they	
				are aware of which	
				investigations with which they are required to assist, a	
				well as the specific	
				components of the	
				investigation for which they	
				are responsible, within the	
				five business day timeframe.	
			I		

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	T OF DEFICIENCIES X1) PROVIDER/SU DF CORRECTION IDENTIFICATION I 15G447	NUMBER:	2) MULTIPLE COI BUILDING WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/21/2015		
	ROVIDER OR SUPPLIER DRPORATION OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEF (EACH DEFICIENCY MUST BE PREC REGULATORY OR LSC IDENTIFYING	EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				The Clinical Supervisor will review each investigation to ensure that they are thorough —meeting regulatory and operational standards, and will not designate an investigation, a completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members. The Residential Manager will develop and maintain a staffin matrix that assures adequate direct support staff who posse the training, skills and capabilit to provide appropriate active treatment and assure the heal and safety of clients at all time Members of the Operations Teand the QIDP will conduct active treatment observations and documentation reviews no less than five times weekly for the	g ss ties th ss. eam ve s		

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Event ID:

18FZ12

Facility ID: 000961

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G447	B. WING		01/21/2015
				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF P	PROVIDER OR SUPPLIER			NOLLTON RD	
VOCA CO	ORPORATION OF I	NDIANA		IAPOLIS, IN 46228	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
				21 days, no less than 3 times weekly for an additional 14 Da and no less than twice weekly an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Administrative support at the home will focus on mentorship and training of supervisory stamonitoring and coaching of dissupport staff, and evaluation of the effectiveness of current risplans and safety protocols. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Teal	for ne off, rect of ik
W000149	written policies and mistreatment, neg Based on observer record review for (B and C) and for the facility negle written policy and neglect of the clithe bathroom to pand injuries. The implement its written policies to continue to cont	evelop and implement d procedures that prohibit lect or abuse of the client. ation, interview and r 2 of 4 sampled clients r 1 additional client (H), cted to implement its d procedures to prevent ent in regard to falls in prevent potential falls e facility neglected to citten policy and	W000149	CORRECTION: The facility must develop and implement written policies and procedure that prohibit mistreatment, negor abuse of the client. Specific The facility has located the investigation into Client H's discovered injury on 11/5/14. The Residential Manager responsible for failing to complet thorough investigations of Client C's falls and Client B, C and H's injuries of unknown origin has been removed from the facility and no longer serves in a formal	glect cally:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED
		15G447	B. WIN			01/21/2015
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				NOLLTON RD	
VOCA CO	ORPORATION OF I	NDIANA			APOLIS, IN 46228	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	source for clients	s B, C and H, and to			supervisory capacity.	
	ensure corrective	e measures were put in			ADDENDUM 2/17/15: The	
	place for client C	in regard to the client's			Operations Team, including	
	falls.	_			the Program Manager and	
					QIDP, will directly oversee al investigations. The	1
	Findings include				Residential Manager will	
	Tilldings illetude	•			receive additional training	
	1.5 1.1/12/15 1				toward assisting with	
	1. During the 1/13/15 observation period				gathering evidence, including	g
between 5:04 PM and 6:45 PM and the 1/14/15 observation period between 6:14					conducting thorough witness	
					interviews. The Clinical	
	AM and 8:30 AM, at the group home, client C utilized a wheelchair for				Supervisor and Program	
					Manager will assure that	
	mobilization. Cl	ient C did not wear a			conclusions are developed	
	seatbelt when in	the wheelchair. Client C			that match the collected	
		around the client's waist.			evidence. The governing Bod	У
	Specifically duri				will assume complete	
		od, client C sat forward			responsibility for investigating any discovered	
	-	heelchair seat. Client C			injuries that require outside	
	_				medical treatment. When an	v
		irected to sit/scoot back			evidence of staff negligence	
		r and to sit up straight.			is uncovered or alleged the	
	_	15 observation period,			Operations Team will take	
		re were 2 direct care staff			control of all aspects of the	
	` ′	and the group home			investigation process.	
	manager (staff#	1) at the group home.				
	Staff #6 was assi	sting clients to get up				
	and get dressed a	and staff #1 was assisting				
	client #8 to prepa	are breakfast. Staff #4				
	was in the medic	ation room passing the			Client C has begun receiving	
		tions. Staff #4 stayed in			twice weekly physical therapy	
	the medication ro	_			sessions and a daily home	
		od except to come out of			exercise program has been	
	•	oom to get clients for her			initiated to enhance Client C's core strength to diminish the	
		tions. Staff #4 did not			incidence of falls such as	
	_				occurred on 12/12/14 and	
	assist with the br	eakfast meal when			occurred on 12/12/17 and	

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Event ID:

18FZ12

Facility ID: 000961

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		15G447	A. BUII B. WIN			01/21/	2015
		l .	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	Ь	
NAME OF I	PROVIDER OR SUPPLIEF	₹			NOLLTON RD		
VOCAC	ORPORATION OF	INDIANA			APOLIS, IN 46228		
VOCAC	URFURATION OF	INDIANA		INDIAN	APOLIS, IN 40228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	clients were not	getting medications.			12/15/14. An Occupational		
	Staff #4 wore a	nasal oxygen tube while			Therapy evaluation has been		
	carrying a portal	ole oxygen container with			scheduled for Client C to evaluat	e	
	her. During the				the effectiveness of current		
	_	od, client C required			adaptive equipment and to obtai	n	
	-	-			recommendations for		
	stand by and/or physical assistance when				enhancements. In the interim,		
	1	n her wheelchair to the			after appropriate due process,		
		physically assisted client			the team will provide the following adaptive modifications:	.	
	C to stand while	grabbing the client's gait			the seat belt will be re-fitted to		
	belt to steady the	e client during the			Client C's wheelchair and a chair		
	transfer. Client	_			alarm will be installed to alert		
		walking as the client was			staff when the seat belt has		
		required staff physical			become unfastened. Client C will		
					receive enhanced supervision		
		ll when ambulating as the			-line of sight observation and 15	j	
		lker and wore a gait belt			minute checks while in her		
	for transfers. Cl	ient B required staff			bedroom. A bed alarm and audio)	
	supervision and	monitoring due to the			monitor will be placed in her		
	client's behavior	of trying to get into the			bedroom. The team will also		
	kitchen to drink				provide a modified toilet seat		
		(001100).			with side rails. The nurse will		
	The Coniliant non				modify Client C's Comprehensive	:	
		portable incident reports,			High Risk Plan for falls to clarify		
		ernal Incident/Accident			the expectations for "stand by"		
		and/or investigations			assistance while Client C is in the	<u> </u>	
	were reviewed o	on 1/14/15 at 11:17 AM.			bathroom including but not		
	The facility's rep	portable incident reports,			limited to hands on use of a gait		
	IARs and/or inv	estigations indicated the			belt at all time while client C is		
	following (not a				toileting and showering.		
	10110 Willig (110t a						
	11/11/14 011						
	_	n arrival to group home			PREVENTION:		
		idividual Supported by					
	, ,	at been assisted off the			ADDENDUM 2/17/15: A		
	van and into the	group home by staff. As			tracking spreadsheet for		
	the staff continu	ed to assist the other			incidents requiring		
		he van (sic) [client C]			investigation, follow-up and		
	individuals off the	ne van (sie) [enent e]	1		· ·		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G447	B. WIN	G		01/21/2015
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TWINE OF T	KO VIDEK OK SOIT EIEN				NOLLTON RD	
VOCA CO	ORPORATION OF	INDIANA		INDIAN	IAPOLIS, IN 46228	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
		into the bathroom			corrective/protective measures will be maintained	
		omeone to assist her.			and distributed daily to	
		was in the bathroom she			facility supervisors and the	
	proceeded to tak	e off her brief and pants			Operations Team. The Clinica	al
	causing her to fa	ll to her knees causing an			Supervisor (Administrative	
	(sic) half inch in	diameter injury to the			level management) will mee	t
	right knee. The area was cleaned with				with his/her facility	
	peroxide and ointment applied to the area				management teams weekly	
	and covered with bandaide (sic)[Client				to review the progress made	
	C] has a high risk plan for falls in place				on all investigations that are	1
	and staff will continue to implement her				open for their homes. Residential Managers will be	
	plan and give her moral support. The				required to attend and sign	'
	interdisciplinary team will be meeting to				an in-service at these	
		ways to ensure [client			meetings stating that they	
		ways to ensure [chefit			are aware of which	
	C's] safety."				investigations with which	
	10/10/14 !! 4	(they are required to assist, a	S
		(staff #5) brushed [client			well as the specific	
	-	s complaining of pain on			components of the investigation for which they	
		brushed. I asked her			are responsible, within the	
	what was wrong	(sic) she stated that she			five business day timeframe.	
	fell as she got up	off the toilet and hit her			The Clinical Supervisor will	
	head on the toile	t seat." The IAR			review each investigation to	
	indicated "The	re is a scratch that is a			ensure that they are	
	(sic) inch long it	is red and sore to the			thorough -meeting	
	touch (sic)."				regulatory and operational	
					standards, and will not	.
	The facility's 12	/31/14 follow-up report			designate an investigation, a completed, if it does not mee	
		reportable incident report			these criteria. The Program	
		nt C's] injury has healed			Manager will also conduct	
	_	edical treatment was			spot checks of investigations	5,
		g the investigation it was			focusing on serious incidents	s
	l '	•			that could potentially have	
	_	e staff that worked that			occurred as a result of staff	
		c] was assisted to the			negligence. The Clinical	
	bathroom into he	er bed with no injuries			Supervisors will provide	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION	(X3) DATE SU	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIHLD	INC	00	COMPLET	TED
		15G447	A. BUILDI B. WING	ING		01/21/20	015
				STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			NOLLTON RD		
VOCA C	ORPORATION OF	ΙΝΠΙΔΝΙΔ			APOLIS, IN 46228		
	T				AI OLIO, IIN 1 0220		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	·		DATE
		vening. [Client C]			weekly updates to the		
		at she had fell (sic) and			Program Manager on the		
	could not remember when she fell. Staff				status of investigations.	, l	
	are being retrain	ned on [client C's] high			Failure to complete thoroug investigations within the	"	
	I -	s and will monitor [client			allowable five business day		
	C] more closely	-			timeframe will result in		
		•			progressive corrective actio	n	
	The feether 12	1/12/14 attached witness			to all applicable team		
	The facility's 12/12/14 attached witness statements/investigation in regard to the				members.		
	injury of unknown source indicated only						
	2 direct care staff were interviewed in regard to client C's injuries. The staffs'				The Residential Manager wil		
					develop and maintain a staffii	~	
	witness stateme	nts indicated the			matrix that assures adequate		
	following:				direct support staff who posse the training, skills and capabi		
	<i>S</i> .				to provide appropriate active		
	Staff #7 was in	terviewed on 12/12/14.			treatment and assure the hea	alth	
		ss statement indicated			and safety of clients at all time		
					Members of the Operations T	eam	
		all at least I don't think			and the QIDP will conduct ac	tive	
		take her and usually she			treatment observations and		
		she fell. She would like			documentation reviews no les		
	(sic) 'I fall, I fall	l'."			than five times weekly for the 21 days, no less than 3 times		
					weekly for an additional 14 D		
	-Staff #8 was in	terviewed on 12/12/14.			and no less than twice weekly	-	
		ss statement indicated			an additional 60 Days. At the		
		I assisted her to the			conclusion of this period of		
		isted on the toilet and off			intensive administrative		
					monitoring and support, the		
		o she didn't fall cause if			Operations Team will determi	ine	
		ld of (sic) needed to assist			the level of ongoing support needed at the facility.		
	her up together.	"			Administrative support at the		
					home will focus on mentorshi	p	
	The facility's 12	1/12/14 investigation			and training of supervisory sta	•	
	1	cility attempted to			monitoring and coaching of d		
		elients who lived in the			support staff, and evaluation		
					the effectiveness of current ri	sk	
	group nome. The	ne facility's investigation			plans and safety protocols.		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447			LDING	00	(X3) DATE COMPL 01/21 /	ETED	
NAME OF F	ROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD		
VOCA C	ORPORATION OF	NDIANA			APOLIS, IN 46228		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	indicated client I 12/12/14 at 5:45 statement indicated [staff #7] put [client K] put [client K] put [client C] to the statement C] to the statement indicated the toilet and tole [client C] got up was in the living C] yell. I didn't the living room.' investigation negated additional follow questions were compared additional follow questions were conclusion, and/or ecommendation. The facility's investige environment was conclusion, and/or ecommendation. The facility's 12/indicated the Qu Disabilities Profect conducted the facility individual supply using the toilet. The facility is a washelf the commode and in a 1/2 (one halt called 911 and E Services) transport	H was interviewed on PM. Client H's witness ted "I didn't actually see tent C] on the toilet. I her [staff #7] bring bathroom and put her on d her not to move and on her own and fell. I room and heard [client see anything. I was in 'The facility's glected to indicate any y-up interviews and/or onducted in regard to d statements. The gation did not indicate the se checked, did not have a for indicate any additional is for corrective actions.			CROSS-REFERENCED TO THE APPROPRIA	t	
	treatment via am	bulance. ER (emergency					

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Event ID:

18FZ12

Facility ID: 000961

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G447	B. WIN	G		01/21/2015
NAME OF F	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					NOLLTON RD	
VOCA C	ORPORATION OF I	INDIANA		INDIAN	APOLIS, IN 46228	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		closed and dressed the				
	" "	ed [client C] to ResCare				
		I care instructions.				
		ing comfortably at home				
	and staff will per	rform neuro				
	(neurological) ch	necks for 24 hours per				
	protocol. [Clien	t C] has a history of falls				
	and a Comprehe	nsive High Risk Plan is				
	in place, the risk	plan for falls directs				
	staff to provide her with stand-by					
	assistance while transferring to and from					
	the toilet. Preliminary inquiry suggests					
	staff followed th	e protocols in the plan.				
		etheless investigating the				
		f the incident to assure				
		propriate supports"				
		1 1 11				
	The facility's 12/	15/14 IAR indicated				
		ing [client C] with				
		e and had her seated on				
	1	ff was at face basin				
		over and immediately				
		er on to the floor. Staff				
		rming under the left side				
		The IAR indicated client				
	C had "about a					
		e 12/15/14 IAR was				
	filled out by staf					
	inica out by star	1 11 / .				
	The facility's 12	/15/14 investigation				
	1	4 was also working at the				
		ent. The facility's				
		•				
	· ·	gation indicated staff #4				
	was interviewed	on 12/15/14. Staff #4's				

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18FZ12

Facility ID: 000961

If continuation sheet

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPL	
		15G447	B. WIN	NG		01/21/	2015
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
VOCA C	ORPORATION OF	ΙΝΙΣΙΑΝΙΑ			NOLLTON RD APOLIS, IN 46228		
					AFOLIS, IN 40220		77.0
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	witness stateme	ent indicated "I (staff #4)					
		Only thing I know when I					
		other bathroom, [staff					
		d on the door and told me					
	_	ell (sic) and it is so much					
		out of the bathroom and					
		ying on her left side. So I					
		[#9] to call the nurse.					
	[Staff #9] came	back and told me nurse					
	said to call 911	and she did. I said to					
	[staff #9] just le	et her lay until Amb.					
	(ambulance) co	mes."					
	The facility's 12	2/15/14 investigation					
	indicated client	C was interviewed on					
	12/15/14. Clier	nt C's witness statement					
	indicated the cli	ient fell in the bathroom at					
	the back of the	house. The witness					
	statement indica	ated client C could not					
	identify the staf	f who was with her.					
	Client H's 12/15	5/14 witness statement					
	indicated client	H did not see when the					
	incident occurre	ed. Client H's witness					
		ated "I didn't see I just					
	heard them talk	ing [staff #9] and [staff					
		heard [staff #9] ask [staff					
	#4] to help her.	I was in my room getting					
	dressed."						
		15/14 Progress Note					
	_	ent C] had Nasty fall in the					
		M, while being assist					
	` ′ •	ember. Slid down off					
	toilet as staff wa	as trying to wash her.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447		(X2) MUI A. BUILI B. WING	DING	00	(X3) DATE : COMPL 01/21 /	ETED	
NAME OF I	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP CODE	-	
VOCA C	ORPORATION OF	INDIANA			IOLLTON RD APOLIS, IN 46228		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
140	[Client C] fell for Nurse was called emerg. (emerger to Hosp. (hospital facility's investig (interdisciplinary discussed the difference of the prevent future facility wheelchair and be when she is getting without assistant recommendations schedule for PT (appointment)." investigation independent of the bathroom. In the staff monitored of the bathroom. The did not question was placed on the why client C was sitting on the toil investigation did staff was specific C fell off the toil investigation neeplace corrective client C from positive to the positive of the positive of the positive of the positive of the toil investigation neeplace corrective client C from positive of the po	orward and hit her head. If and she stated to call hey). She was then taken all) for observation." The gation indicated "IDT by team) met and afferent ways to help alls such as seat belt for bed alarm to alert staffing out of bed or chair hee. Also a a from ER physician to (Physical Therapy) apt.		IAU			DATE

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Event ID:

18FZ12

Facility ID: 000961

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G447	B. WIN			01/21/	2015
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
VOCA CO	ORPORATION OF I	ΙΝΠΙΔΝΙΔ			NOLLTON RD APOLIS, IN 46228		
			-	l	Al OLIO, III 40220		715
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	, The state of the	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	could meet the n	eeds of the clients. The					
		4 investigation indicated					
	1	eted the investigation.					
	F						
	Client C's record	was reviewed on					
	1/14/15 at 1:16 PM. Client C's 12/15/14						
	Record Of Visit	(ROV) indicated client C					
	was seen at a loc	al hospital due to a fall.					
	The ROV indica	ted client C had a					
	"Forehead laceration. Normal head CT						
	(cat scan) and cervical spine CT. Keep						
	wound dry for 24	4 hours then wash as					
	usual. Watch for	r signs of infection.					
	Recommend PT	for strengthening and					
	fall prevention."						
		14 ROV indicated client					
		e ER due to a fall. The					
		Frontal Forehead					
		Abrasion. Forehead					
		ion. Head Injury					
	instructions. Tyl	ienoi for pain."					
	Client C's 12/15/	14 nurse note indicated					
		se went to the group					
		lient C after she returned					
		ne nurse note indicated					
		tched facility staff					
		t from the wheelchair to					
		the wheelchair to the					
		a gait belt and pivot to					
		ansfer. The nurse note					
		sumer had a folded up					
		overing the wound on					
	1	<i>G</i>					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G447	B. WIN			01/21/	2015
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
VOCA C	ORPORATION OF I	NDIANA			NOLLTON RD APOLIS, IN 46228		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	forehead from fa						
	-	cal tape. Staff reported					
	that while in the	ER, the doctor there					
	used a glue-like	substance to close the					
	wound together.	Staff also reported that					
	the ER doctor ha	d advised not to cleanse					
	the area until the	next day. The size of					
	the wound was a	pprox. (approximately) 1					
	inch in lengthC	Consumer was present					
	during the IDT n	neeting, and it was					
	discovered that s	he 'scoots' herself around					
	in her wheelchai	r, but she leans forward					
	in order to do thi	s." Client C's nurse					
	notes and/or reco	ord indicated the facility					
		cate when and/or if a PT					
	_	een set up/scheduled.					
		•					
	Client C's 5/13/1	4 Health Supports					
	Addendum indic	ated client C has an					
	unsteady gait. T	he addendum indicated					
	, ,	lient C] has had several					
		lt of falls; therefore					
	[client C] curren						
		n though [client C]					
		hair, she still continues					
		ting to use it properly					
		stance to move into seats					
	•	hairShe will continue					
		luation annually"					
		j					
	Client C's 5/13/1	4 Individual Support					
		ated "3.) [Client C]					
	i i	proper precautions when					
		wheelchair, despite staff					
	uniounum girel v	meerenan, despite stan					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CON	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	
		15G447	B. WING			01/21/	2015
NAME OF I	PROVIDER OR SUPPLIER	1			DDRESS, CITY, STATE, ZIP CODE		
VOCA C	ORPORATION OF	INDIANA			IOLLTON RD APOLIS, IN 46228		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PI	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	prompting her of	therwise. She needs					
		ons to make sure her seat					
		c), the team agreed to					
	continue this goa	· · · · · · · · · · · · · · · · · · ·					
	1	appropriate manner). 4.)					
		having slight problems					
	-	istance in doing things					
	that require her t	0 0					
		he past, [client C] has					
		lling when trying to					
	move out of her						
	move out of her	wheelenan.					
	Client C's undate	ed Decreased Mobility					
		h Plan indicated client C					
	_	ir for all mobility. The					
		ed "4. Staff to provide					
	•	nce when entering and					
		5. Staff to provide					
		ce during in home					
	*	cises. 6. Staff to provide					
		assistance during					
	1	ng/toileting. 7. Should					
	fall occur NOTI	•					
	immediately"						
	miniculatory						
	Client C's record	I indicated client C had					
		ed policy titled FALL					
		PROTOCOL in the					
		The undated policy					
		CY: Falls occur among					
	people who are v						
		_					
		e data obtained from the					
	iaii fisk assessm	ent will identify which					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CON	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	15G447	A. BUILD	ING	00	COMPL 01/21/	
		196447	B. WING			01/21/	2015
NAME OF F	PROVIDER OR SUPPLIER	₹			DDRESS, CITY, STATE, ZIP CODE		
\(\(\text{O} \) \(\text{O} \)		INIDIANIA			IOLLTON RD		
VOCA CO	ORPORATION OF	INDIANA		INDIANA	APOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	ire special measures to					
	. ^	he risk for falls can be					
	reduced by seve	ral factors as outlined					
	below.						
	PROCEDURE:						
	1. Staff should	orient the person to the					
	environment.	•					
	2. Staff should	provide nonskid					
	footwear, mats a	-					
	100tweat, mats t	ina rago.					
	3 Adequate ligi	hting in the environment.					
	3. Macquate fig.	nting in the chynomicat.					
	1 Close superv	ision, when applicable.					
	4. Close superv	ision, when applicable.					
	5 Dlace hade in	lowest appropriate					
	position as defin	led by the IDT.					
	6 6:1:	: C 1: 1.1 -					
	6. Side rails up	ii applicable.					
		ulatory aids, when					
	applicable.						
		cations administered that					
	increase risk of	falling.					
	9. Should fall o	ccur staff will notify					
	nurse immediate	ely					
	13. IDT will me	eet to discuss					
	individualized fa	all prevention per					
		vior Support Plan) or					
	l ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` `	,	1				

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MULT A. BUILDIN B. WING		OO	(X3) DATE : COMPL 01/21/	ETED
	PROVIDER OR SUPPLIER		S' 4	114 KN	ODDRESS, CITY, STATE, ZIP CODE OLLTON RD APOLIS, IN 46228	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Client C's record IDT Meeting not -11/6/14 Client C	indicated the following tes (not all inclusive): C's IDT met to follow up visit. The IDT note					
	indicated on 7/20 out (sic) the bed asking for assistate to put her wheeles so she can call for	6/14 "[Client C] fell getting out without nnce. The team decided chair away from her bed or help. Staff also have ousemate not to try to					
	to the bathroom	-					
	scratch on her he staff when they was a constant of the staff when they was a constant of the staff when the staff when the staff white completing Living skills). So wash out the face	existed that was noticed by were brushing her hair. The fell. [Client C] is self off the floor so an being conducted to nappened. In C] fell off the toilet g her ADL's (Adult Daily taff said she turned to be towel and [client C] alance and fell off the					

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PRINTED: 03/06/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 01/21 /	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD					
VOCA C	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46228			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	toilet. Staff assifloor. [Client C] forehead. She was treated a prevention meth belt for her wheed discussed [client secured around he when she is on the falling. [Client of the from a bed and of when she is tryin with assistance (suggestions requested to devention and/or record in the neglected to devention and/or record in the specifically indicated the specifical three specifical that the specifical three specifi	sted [client C] off the had a gash on her was taken to ER where and released. As a cod [client C] needs a seat elchair. The team also code in the compart of						

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Facility ID: 000961

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G447	B. WIN	G		01/21/	2015
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KO VIDEK OK SOIT EIEN				NOLLTON RD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		stand on her own."					
		w many staff normally					
		ning, confidential					
		ed "Two for the most					
	part."						
		erview B stated when					
	asked how client	t C was to be					
	supervised/moni	tored in the bathroom,					
	"Help her in ther	e. Help on commode.					
	Maneuver to sit	down and hold onto gait					
	belt. We come of	out and then she calls us					
	when ready. We	e go back in there and					
	help her up and l	hold onto gait belt."					
	Confidential inte	erview B indicated client					
	C was to hold or	to the safety bar in the					
		l. When asked how					
	often client C fel	Il, confidential interview					
		at much. She will jump					
		nair unlocked and fall.					
	^	g and find her on floor."					
		8					
	Interview with s	taff #4 on 1/14/15 at 7:35					
		ient C fell last month.					
		staff was giving the					
		off. Turned to rinse					
		She (client C) fell on					
		ked if client C had fallen					
		ore, staff #4 stated "Quite					
		not fallen on my shift."					
	a rew times, but	not fairen on my sillit.					
	Interview with C	Clinical Supervisor (CS)					
		d LPN #1 on 1/14/15 at					
		ed client C was a fall					
	J.JJ I WI IIIUICAN	ou chichi C was a fall					

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AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447			LDING	NSTRUCTION 00	(X3) DATE COMPL 01/21 /	ETED		
NAME OF I	PROVIDER OR SUPPLIER	<u>. </u>	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
VOCA C	ORPORATION OF	INDIANA	4114 KNOLLTON RD INDIANAPOLIS, IN 46228					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION) licated 2 staff (staff #4		TAG	DEFICIENCY)		DATE	
		re working on 12/15/14						
	· · · · · · · · · · · · · · · · · · ·	ll off the toilet. CS #1						
		dicated staff #9 was in						
	-	nen client C fell off the						
		P indicated she did not						
	-	to why client C was						
		f on the toilet. The QIDP						
		ated there were no						
		nterviews/conducted.						
		IDP indicated the facility						
		witness statement from						
	staff #9. CS #1	indicated staff #9 filled						
	out the incident	report and the facility						
		ner witness statement.						
	When asked how	v the client fell off the						
	toilet, the QIDP	stated "She leaned						
	forward and fell.	" The QIDP and CS #1						
	indicated the fac	ility's investigation did						
	not look at how	client C was placed/sat						
		taff to ensure the client						
		ced on the toilet. CS #1						
		ty staff normally worked						
		CS #1 and the QIDP						
		4 was 1 of the 2 staff						
		the morning shift. CS #1						
		ility neglected to look at						
	_	the group home to						
		y staff, who worked in						
	1	meet the needs of the						
	,	OP indicated client C's						
		iewed the falls and made						
		is. LPN #1 and the QIDP						
	indicated chent	C was to see the PT on						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	COMPI		
AND PLAN	OF CORRECTION	15G447	A. BUI	LDING	00	COMPL 01/21/	
		100441	B. WIN			01/21/	۷۱۱۵
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
VOCA CO	ORPORATION OF I	INDIANA			NOLLTON RD APOLIS, IN 46228		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1/15/15. The QI						
		Γ's recommendations to					
		and wheelchair/bed					
		een purchased as they					
	_	the PT evaluation to be					
	•	QIDP and LPN #1					
	1	staff were to stay in the					
		lient C when she was					
	bathing and bein	g toileted to prevent the					
	client from fallin	g. The QIDP and CS #1					
	indicated the fac	ility did not conduct any					
	additional interv	iews in regard to client					
	C's injury of unk	nown source of					
	12/12/14. QIDP	#1 indicated client C					
	had indicated sho	e fell. The QIDP and CS					
	#1 indicated only	y 2 staff were					
	interviewed and	they did not know how					
	client C received	I the injury to the client's					
	head. The QIDP	indicated facility staff					
	indicated client (C did not fall. When					
	asked if client C	s fall risk plan had been					
	updated, LPN sta	ated "No." The QIDP					
	and LPN #1 indi	cated client C's mobility					
	risk plan and/or	record did not indicate					
	how facility staff	f were to monitor client					
	C when in the ba	throom to prevent					
	potential falls an	d/or injuries.					
	2. The facility fa	ailed to conduct thorough					
	investigations in	regard to allegations of					
	_	and/or injuries of					
		for clients B, C and H.					
	Please see W154						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G447	B. WIN	IG		01/21/	2015
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					NOLLTON RD		
VOCA CO	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	ailed to put in place					
		ares to prevent client C					
	from falling in th	ne bathroom. Please see					
	W157.						
		licy and procedures were					
	reviewed on 1/14	4/15 at 11:02 AM. The					
	facility's 2/26/1	1 policy entitled Abuse,					
	Neglect, and Exp	ploitation indicated					
	"Adept staff acti	vely advocate for the					
	rights and safety	of all individuals. All					
	_						
	•	• • •					
	•						
	-						
		•					
		•					
	•	•					
		-					
		-					
	* *	•					
		•					
	•						
		•					
		•					
	_	ould indicate/include					
	"Methods (cor	rective actions) to					
	prevent future in	cidents."					
	Neglect, and Exp "Adept staff active rights and safety allegations or occure neglect, exploitate shall be reported authorities throughly investigations of Adept state and federal facility's policy of "Failure to proservices necessate avoid physical has the support neces psychological are Failure to meet to requirements successed in the support neces psychological are policy and to penvironment" policy also indicativestigations we "Methods (corrected)	ploitation indicated vely advocate for the of all individuals. All currences of abuse, tion, or mistreatment to the appropriate gh the appropriate mels and will be stigated under the t, Rescare, and local, guidelines." The defined neglect as vide goods and/or rry for the individual to arm. Failure to provide ssary to an individual's ad social well being. he basic need ch as food, shelter, provide a safe The facility's 2/26/11 ated the facility's ould indicate/include rective actions) to					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ĺ ´	(X2) MULTIPLE CO	(X3) DATE SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		15G447	B. WING		01/21/2015		
NAME OF P	ROVIDER OR SUPPLIER	-		ADDRESS, CITY, STATE, ZIP CODE			
			4114 KNOLLTON RD				
VOCA CO	ORPORATION OF	INDIANA	INDIAN	IAPOLIS, IN 46228			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE	DATE		
		was cited on 11/12/14.					
	_	ed to implement a					
	systemic plan of	correction to prevent					
	recurrence.						
	9-3-2(a)						
W000154	403 430(4)(3)						
W000134	483.420(d)(3) STAFF TREATME	ENT OF CLIENTS					
	_	nave evidence that all					
	alleged violations						
	investigated.						
	Based on observ	ation, interview and	W000154	CORRECTION: The facility	02/20/2015		
	record review fo	r 4 of 5 allegations of		must have evidence that all	ubly.		
	abuse, neglect ar	nd/or injuries of unknown		alleged violations are thoroug investigated. Specifically:	The		
	source reviewed	, the facility failed to		facility has located the			
	conduct thoroug	h investigations in regard		investigation into Client H's			
	to allegations of	possible neglect and/or		discovered injury on 11/5/14.			
	_	own source for clients B,		The Residential Manager			
	C and H.	,		responsible for failing to comple			
				thorough investigations of Clien C's falls has been removed from			
	Findings include	•		the facility and no longer serves			
	8			in a formal supervisory capacity			
	1 During the 1/	13/15 observation period		ADDENDUM 2/17/15: The			
	•	A and 6:45 PM and the		Operations Team, including			
		tion period between 6:14		the Program Manager and	_		
		•		QIDP, will directly oversee a	all		
		M, at the group home,		investigations. The Residential Manager will			
	client C utilized			receive additional training			
		lient C did not wear a		toward assisting with			
		the wheelchair. Client C		gathering evidence, includir	ng		
	_	around the client's waist.		conducting thorough witnes			
	Specifically duri	· ·		interviews. The Clinical			
	•	od, client C sat forward		Supervisor and Program			
	on the edge of w	heelchair seat. Client C		Manager will assure that			
			1	conclusions are developed			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G447	B. WIN	G		01/21/	2015
NAME OF E	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	KO VIDEK OK GOTT EIEN				NOLLTON RD		
VOCA C	ORPORATION OF I	INDIANA		INDIAN	IAPOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	_	irected to sit/scoot back			that match the collected		
		r and to sit up straight.			evidence. The governing Boo will assume complete	ıy	
	During the 1/14/	15 observation period,			responsibility for		
	upon arrival, the	re were 2 direct care staff			investigating any discovered	ı	
	(staff #4 and #6)	and the group home			injuries that require outside		
	manager (staff#	1) at the group home.			medical treatment. When an		
		isting clients to get up			evidence of staff negligence	-	
		and staff #1 was assisting			is uncovered or alleged the		
	~	are breakfast. Staff #4			Operations Team will take		
		eation room passing the			control of all aspects of the		
					investigation process.		
	I -	tions. Staff #4 stayed in					
	the medication re						
	_	od except to come out of			PREVENTION:		
	the medication re	oom to get clients for her			TREVERTION		
	morning medicat	tions. Staff #4 did not			ADDENDUM 2/17/15: A		
	assist with the br	reakfast meal when			tracking spreadsheet for		
	clients were not	getting medications.			incidents requiring		
	Staff #4 wore a r	nasal oxygen tube while			investigation, follow-up and		
		ole oxygen container with			corrective/protective	_	
	her. During the				measures will be maintained	1	
		od, client C required			and distributed daily to facility supervisors and the		
		physical assistance when			Operations Team. The Clinical	al	
					Supervisor (Administrative	.	
	_	h her wheelchair to the			level management) will mee	t	
		physically assisted client			with his/her facility		
		grabbing the client's gait			management teams weekly		
		e client during the			to review the progress made		
	transfer. Client	-			on all investigations that are	•	
	assistance when	walking as the client was			open for their homes.		
	blind. Client E r	required staff physical			Residential Managers will be	•	
	assistance as wel	ll when ambulating as the			required to attend and sign an in-service at these		
		lker and wore a gait belt			meetings stating that they		
		ient B required staff			are aware of which		
		monitoring due to the			investigations with which		
	_	of trying to get into the			they are required to assist, a	ıs	
	Cheni s Denavioi	or trying to get into the			,		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G447	B. WIN	G		01/21/2015
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE	
					NOLLTON RD	
VOCA CO	ORPORATION OF	INDIANA		INDIAN	IAPOLIS, IN 46228	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	,	DATE
	kitchen to drink	tea (coffee).			well as the specific	
					components of the investigation for which they	
		portable incident reports,			are responsible, within the	
	the facility's inte	ernal Incident/Accident			five business day timeframe.	
		and/or investigations			The Clinical Supervisor will	
	were reviewed o	on 1/14/15 at 11:17 AM.			review each investigation to	
	The facility's rep	portable incident reports,			ensure that they are	
	IARs and/or inv	estigations indicated the			thorough -meeting	
	following (not a	ll inclusive):			regulatory and operational standards, and will not	
					designate an investigation, a	ne l
	-12/12/14 "As I	(staff #5) brushed [client			completed, if it does not mee	
		as complaining of pain on			these criteria. The Program	
	1 -	I brushed. I asked her			Manager will also conduct	
		(sic) she stated that she			spot checks of investigations	
	_	o off the toilet and hit her			focusing on serious incidents	5
		et seat." The IAR			that could potentially have	
		ere is a scratch that is a			occurred as a result of staff negligence. The Clinical	
					Supervisors will provide	
	1 ' '	t is red and sore to the			weekly updates to the	
	touch (sic)."				Program Manager on the	
	TEL 6 :1: 1 10	/01/14 6 11			status of investigations.	
	1	/31/14 follow-up report			Failure to complete thorough	1
		reportable incident report			investigations within the	
		loing the investigation it			allowable five business day	
		om the staff that worked			timeframe will result in progressive corrective action	,
	1	ent C] was assisted to the			to all applicable team	•
	bathroom into he	er bed with no injuries			members.	
	1	vening. [Client C]			RESPONSIBLE PARTIES	:
	however said that	at she had fell (sic) and			QIDP, Residential Manager,	
	could not remen	nber when she fell. Staff			Team Leader, Direct Support	
	are being retrain	ed on [client C's] high			Staff, Operations Team	
	risk plan for fall	s and will monitor [client				
	C] more closely.					
	The facility's 12	/12/14 attached witness				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPL 01/21/	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0	
NAME OF I	PROVIDER OR SUPPLIEF	(NOLLTON RD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATIONS		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	statements/investinjury of unknow 2 direct care staff regard to client 0 witness statement following: -Staff #7 was int Staff #7's witnes "No she didn't fashe did. I didn't would tell me if (sic) 'I fall, I fall -Staff #8's witnes "She didn't fall. bathroom. I assist and into bed. No she did we would her up together.' The facility's 12 indicated the fact interview all 8 c group home. The indicated client of the staff #7] put [cl think I seen (sic) [client C] to the the toilet and toles.	s statement indicated all at least I don't think take her and usually she she fell. She would like '.'' serviewed on 12/12/14. It is statement indicated I assisted her to the listed on the toilet and off to she didn't fall cause if d of (sic) needed to assist		TAG	DEFICIENCY)		DATE
	l ferrent of got ub	on nor own and left. I					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION		A. BUI	LDING	00	COMPL	
		15G447	B. WIN			01/21/	2015
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
VOCA C	ORPORATION OF I	NDIANA			NOLLTON RD APOLIS, IN 46228		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		room and heard [client					
		see anything. I was in					
	the living room.'	' The facility's					
	investigation did	not indicate any					
	additional follow	v-up interviews and/or					
	questions were c	onducted in regard to					
	above mentioned	l statements. The					
	facility's investig	gation did not indicate the					
	environment was	s checked, did not have a					
	conclusion, and/	or indicate any additional					
	recommendation	s for corrective actions.					
	The facility's 12/	12/14 investigation					
	indicated the Qu	alified Intellectual					
	Disabilities Prof	essional (QIDP)					
	conducted the fa	cility's investigation.					
	-12/15/14 "Staff	was assisting [client C]					
	(individual supp	orted by ResCare) with					
	using the toilet.	Staff turned to the side					
	to rinse a washcl	oth and [client C] fell off					
	the commode an	d hit her head resulting					
	in a 1/2 (one half	finch) laceration. Staff					
	called 911 and E	MS (Emergency Medical					
	Services) transpo	orted [client C] to the					
	[name of hospita	l] for evaluation and					
		bulance. ER (emergency					
		closed and dressed the					
	_	ed [client C] to ResCare					
		care instructions.					
	[Client C] is rest	ing comfortably at home					
	and staff will per						
	•	necks for 24 hours per					
		t C] has a history of falls					
	_	nsive High Risk Plan is					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/21/2015
	PROVIDER OR SUPPLIE		4114 k	ADDRESS, CITY, STATE, ZIP CODE KNOLLTON RD NAPOLIS, IN 46228	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	staff to provide assistance while the toilet. Prelir staff followed the The team is non circumstances of staff provided approvided a	transferring to and from minary inquiry suggests are protocols in the plan. The incident to assure opropriate supports" 15/14 IAR indicated ing [client C] with and had her seated on off was at face basin leaver and immediately for on to the floor. Staff rming under the left side of the IAR indicated client a half inch cut on the 12/15/14 IAR was ff #9. 15/14 investigation was also working at the ent. The facility's gation indicated staff #4 on 12/15/14. Staff #4's int indicated "I (staff #4) on the door and told me left (sic) and it is so much ut of the bathroom and			
		ring on her left side. So I #9] to call the nurse.			

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G447	B. WIN			01/21	/2015
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
VOCA C	ORPORATION OF	INDIANA			NOLLTON RD APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		,		TAG	Burelinery		DATE
	-	back and told me nurse and she did. I said to					
		her lay until Amb.					
	(ambulance) con	_					
		ncs.					
	The facility's 12.	/15/14 investigation					
	1	C was interviewed on					
		t C's witness statement					
		ent fell in the bathroom at					
		ouse. The witness					
		ted client C could not					
		who was with her.					
	<u>-</u>	/14 witness statement					
		H did not see when the					
	incident occurred	d. Client H's witness					
	statement indica	ted "I didn't see I just					
		ng [staff #9] and [staff					
	#4]No, I just h	eard [staff #9] ask [staff					
		I was in my room getting					
	dressed."						
	An attached 12/1	5/14 Progress Note					
	indicated "[Clier	nt C] had Nasty fall in the					
	bathroom this A	M, while being assist					
	(sic) by staff me	mber. Slid down off					
	toilet as staff wa	s trying to wash her.					
	[Client C] fell fo	rward and hit her head.					
	Nurse was called	l and she stated to call					
	emerg. (emerger	ncy). She was then taken					
		al) for observation." The					
	facility's investig	gation indicated "IDT					
	(interdisciplinary	y team) met and					
	discussed the dif	ferent ways to help					
	prevent future fa	lls such as seat belt for					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 01/21/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228					
				<u> </u>	711 0210, 114 40220			
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LEG TRENTED BY FORMATIONS		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE	
		bed alarm to alert staff						
		ng out of bed or chair						
	without assistance							
		from ER physician to						
		(Physical Therapy) apt.						
	(appointment)."	-						
	_	icated the facility failed						
		erview with staff #9,						
		staff who had worked						
		determine if staff						
		C while she was in the						
		facility's investigation did						
	-	or ask how client C was						
	•	let, and/or indicate why						
		ng washed while sitting						
		e facility's investigation						
		where each staff was						
		ted when client D fell off						
		acility's 12/15/14						
	_	icated the facility failed						
		taffing levels to ensure						
	· ·	orked, could meet the						
		nts. The facility's						
		gation indicated the						
	QIDP completed	the investigation.						
	Client C's record	was reviewed on						
		PM. Client C's 12/15/14						
		te indicated on "12/12/14						
	_	a scratch on her head that						
		taff when they were						
		r. [Client C] said she						
	_	s unable to get herself						
		n investigation is being						
	011 the 11001 50 a	ii iii oonganon is oonig						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G447	B. WIN	G		01/21/	2015
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
V004 0		INITHANIA			NOLLTON RD		
VOCA CO	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		,		TAG	DEI TOLERO I I		DATE
		ermine what happened.					
	-	nt C] fell off the toilet g her ADL's (Adult Daily					
		taff said she turned to					
	,						
		e towel and [client C] alance and fell off the					
		sted [client C] off the had a gash on her					
		ras taken to ER where					
	she was treated a						
	siic was treated a	mu reicascu					
	 Confidential inte	erview A stated client C					
		past, but had "no falls					
		ntial interview A					
		ere to be in the bathroom					
		en she was in the					
		idential interview A					
		stand on her own."					
		w many staff normally					
		ning, confidential					
		ed "Two for the most					
	part."	ou I we for the most					
	F						
	Confidential inte	erview B stated when					
	asked how client						
		tored in the bathroom,					
	•	re. Help on commode.					
	-	down and hold onto gait					
		out and then she calls us					
		go back in there and					
		hold onto gait belt."					
		erview B indicated client					
		to the safety bar in the					
		l. When asked how					
	bathroom as wel	i. when asked how					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		15G447	B. WIN			01/21/	2015
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF			4114 KI	NOLLTON RD		
	ORPORATION OF				APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
		ll, confidential interview					
		at much. She will jump					
	up from wheelchair unlocked and fall.						
	We hear hollering	ng and find her on floor."					
		taff #4 on 1/14/15 at 7:35					
		ient C fell last month.					
		staff was giving the					
		off. Turned to rinse					
		She (client C) fell on					
	floor." When as	ked if client C had fallen					
	on the floor before	ore, staff #4 stated "Quite					
	a few times, but	not fallen on my shift."					
		Clinical Supervisor (CS)					
	#1, the QIDP and	d LPN #1 on 1/14/15 at					
	3:35 PM indicate	ed client C was a fall					
	risk. The CS inc	dicated 2 staff (staff #4					
	and staff #9) we	re working on 12/15/14					
	when client C fe	ll off the toilet. CS #1					
	and the QIDP in	dicated staff #9 was in					
	,	nen client C fell off the					
		P indicated she did not					
	-	to why client C was					
	_	f on the toilet. The QIDP					
	_	ated there were no					
		nterviews/conducted.					
		IDP indicated the facility					
		witness statement from					
		indicated staff #9 filled					
		report and the facility					
		ner witness statement.					
		v the client fell off the					
	toilet, the QIDP	stated "She leaned					

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IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 01/21/	ETED	
PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228					
SUMMARY S' (EACH DEFICIEN REGULATORY OR forward and fell. indicated the fact not look at how con the toilet by swas properly plate indicated 2 facilities in the morning. indicated staff #4 who worked on the indicated the fact staffing levels at ensure the facilities the home, could clients. The QID the facility did not interviews in regunknown source indicated client (The QIDP and Costaff were interviews how client the client's head. facility staff indifall.	NDIANA FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) "The QIDP and CS #1 ility's investigation did client C was placed/sat taff to ensure the client ced on the toilet. CS #1 ty staff normally worked CS #1 and the QIDP 4 was 1 of the 2 staff the morning shift. CS #1 ility did not look at the group home to y staff, who worked in meet the needs of the DP and CS #1 indicated of conduct any additional ard to client C's injury of of 12/12/14. QIDP #1 C had indicated she fell. S #1 indicated only 2 fewed and they did not C received the injury to The QIDP indicated cated client C did not	B. WIN	STREET A	IOLLTON RD	.	(X5) COMPLETION DATE	
Incident/Accider investigations we at 11:17 AM. The incident reports,	nt Reports (IARs) and/or ere reviewed on 1/14/15 ne facility's reportable IARs and/or dicated the following						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	COMPL		
ANDTLAN	OF CORRECTION	15G447	A. BUI	LDING	00	01/21/	
		100447	B. WIN	_		01/21/	2010
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
VOCA C	ORPORATION OF	INDIANA			NOLLTON RD APOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		arse was doing routine					
	I -	he group home. And					
		ned [client H] (An					
		orted By Rescare) she					
		of [client H's] knees had					
	a light pinkish co	olor to them and the left					
		2/3 (two third) size in					
	diameter sore sh	e had been picking					
	atAn investiga	ation is being conducted					
	into the probable	e cause of the injury"					
	The facility did i	not provide any					
	documentation of	f an investigation in					
	regard to client I	I's injuries of unknown					
	source.						
	-11/5/14 The nu	rse was doing routine					
	body checks in t	he group home. And					
	when she examin	ned [client B] (An					
	Individual Suppo	orted by Rescare) she					
	noticed a bruise	on her right butt cheek a					
	half size in diam	eter (sic). An observed					
		vas reported on October					
		ient B] had a behavior					
	_	self down on the ground					
		sted her up and when the					
		k to the home. (sic)					
		necked for bruising and at					
		as no bruisingAn					
		ll be conducted in to (sic)					
	_	se of the injury"					
	F-15 B-15 B-15 B-16	- · · · · · · · · · · · · · · · · · · ·					
	The facility's 11	/14/14 follow-up report					
		portable incident					
		iducting the investigation					
	Indicated in col	in the substitution					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/21/2015			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	occurred. But it B's] behavior sup drop herself to the from the staff' incident report at follow up report facility documents.	nined how the injury is addressed in [client opport plan that she will he ground to get attention of the 11/5/14 reportable had/or the 11/14/14 did not indicate the ted its investigation in B's injury of unknown						
	AM indicated the and reportable in 11/1/14 to the pro-	e'S #1 on 1/14/15 at 11:15 e facility's investigations acident reports from esent were provided for id not provide any mentation of						
	The facility faile	was cited on 11/12/14. d to implement a correction to prevent						
W000157	483.420(d)(4) STAFF TREATME If the alleged viola corrective action in Based on interviol 1 of 5 allegations injuries of unknown	tion is verified, appropriate	W000157	CORRECTION: If the alleged violation is verified, appropriate corrective action must be take Specifically, Client C has begreceiving twice weekly physical	te en. un			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLE	TED
		15G447	A. BUIL B. WING			01/21/2	015
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				NOLLTON RD		
VOCA CO	ORPORATION OF I	ΙΝΠΙΔΝΔ			APOLIS, IN 46228		
					711 OLIO, 11 1 40220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	· ·	-	DATE
		ent client C from falling			therapy sessions and a daily home exercise program has be	000	
	in the bathroom.				initiated to enhance Client C's		
					core strength to diminish the		
	Findings include	:			incidence of falls such as		
					occurred on 12/12/14 and		
	The facility's ren	ortable incident reports,			12/15/14. An Occupational		
		rnal Incident/Accident			Therapy evaluation has been		
					scheduled for Client C to evalu	uate	
		and/or investigations			the effectiveness of current	ioin	
		n 1/14/15 at 11:17 AM.			adaptive equipment and to obt recommendations for	lairi	
	, ,	ortable incident reports,			enhancements. In the interim,		
	IARs and/or inve	estigations indicated the			after appropriate due process,	the	
	following (not al	l inclusive):			team will provide the following		
					adaptive modifications: the sea	at	
	-11/11/14 "Upon	arrival to group home			belt will be re-fitted to Client C	-	
		dividual Supported by			wheelchair and a chair alarm v		
		t been assisted off the			be installed to alert staff when		
		group home by staff. As			seat belt has become unfaster Client C will receive enhanced		
					supervision –line of sight		
		ed to assist the other			observation and 15 minute		
		ne van (sic) [client C]			checks while in her bedroom.	A	
	wheeled herself	into the bathroom			bed alarm and audio monitor v		
	without asking s	omeone to assist her.			be placed in her bedroom. The		
	While [client C]	was in the bathroom she			team will also provide a modifi	ed	
	proceeded to tak	e off her brief and pants			toilet seat with side rails. The		
	1 *	ll to her knees causing an			nurse will modify Client C's Comprehensive High Risk Pla	n	
		diameter injury to the			for falls to clarify the expectation		
		area was cleaned with			for "stand by" assistance while		
	~				Client C is in the bathroom		
	_	tment applied to the area			including but not limited to han		
		n bandaide (sic)[Client			on use of a gait belt at all time		
		k plan for falls in place			while client C is toileting and		
	and staff will continue to implement her				showering. PREVENTION:		
	plan and give her moral support. The				ADDENDUM 2/17/15: After		
	interdisciplinary team will be meeting to				completing investigations in which the allegations are		
		ways to ensure [client			verified, the QIDP, with the		
	C's] safety."	L .			guidance of the Clinical		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G447	B. WIN			01/21/	/2015
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			NOLLTON RD		
VOCA C	ORPORATION OF	INDIANA			IAPOLIS, IN 46228		
	T				1711 0210, 114 10220		ı
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
					supervisor and Program		
	-12/12/14 "As I (staff #5) brushed [client C's] head she was complaining of pain on				Manger, will bring all releva	int	
					elements of the		
	her head where	I brushed. I asked her			interdisciplinary team together to develop		
	what was wrong	(sic) she stated that she			corrective measures to		
	ı	off the toilet and hit her			ensure the heal and safety	of	
		et seat." The IAR			clients. The Residential		
		ere is a scratch that is a			Manager will develop and		
					maintain a staffing matrix that		
		is red and sore to the			assures adequate direct suppor	t	
	touch (sic)."				staff who possess the training,		
					skills and capabilities to provide	!	
	The facility's 12.	/31/14 follow-up report			appropriate active treatment ar	ıd	
	to the 12/12/14 r	reportable incident report			assure the health and safety of		
		nt C's] injury has healed			clients at all times. Members of		
	_	nedical treatment was			the Operations Team and the		
		g the investigation it was			QIDP will conduct active		
		-			treatment observations and		
		e staff that worked that			documentation reviews no less		
		C] was assisted to the			than five times weekly for the next 21 days, no less than 3		
	bathroom into he	er bed with no injuries			times weekly for an additional 1	4	
	occurring that ev	vening. [Client C]			Days, and no less than twice		
	however said that	at she had fell (sic) and			weekly for an additional 60 Day	S.	
	could not remen	ber when she fell. Staff			At the conclusion of this period		
	are being retrain	ed on [client C's] high			intensive administrative		
		s and will monitor [client			monitoring and support, the		
	C] more closely.	-			Operations Team will determine	2	
	C infore closery.	•			the level of ongoing support		
		44.4			needed at the facility.		
	1	/12/14 investigation			Administrative support at the		
		/12/14 investigation did			home will focus on mentorship		
	not have a concl	usion, and/or indicate			and training of supervisory staff	-	
	any additional re	ecommendations for			monitoring and coaching of dire		
	corrective action				support staff, and evaluation of		
					the effectiveness of current risk		
	_12/15/14 "Staff	was assisting [client C]			plans and safety protocols. RESPONSIBLE PARTIE	c .	
		orted by ResCare) with			QIDP, Residential Manager,	.	
	ı tilidiyiddal SUDD	OLICU DV NESCAIET WILL	1		L G.D. , r Condonida Manager,		Ī

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-	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII		00	COMPL	ETED
		15G447	B. WIN	G		01/21/	2015
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					NOLLTON RD		
	ORPORATION OF I				APOLIS, IN 46228		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	using the toilet.	Staff turned to the side			Team Leader, Health Services	i	
	_	oth and [client C] fell off			Team, Direct Support Staff,		
		d hit her head resulting			Operations Team		
	in a 1/2 (one half	finch) laceration. Staff					
	called 911 and E	MS (Emergency Medical					
	Services) transpo	orted [client C] to the					
	[name of hospita	l] for evaluation and					
	treatment via am	bulance. ER (emergency					
	room) personnel	closed and dressed the					
		ed [client C] to ResCare					
		care instructions.					
		ing comfortably at home					
	and staff will per						
		ecks for 24 hours per					
		t C] has a history of falls					
	•	nsive High Risk Plan is					
	-	plan for falls directs					
	staff to provide h	-					
		transferring to and from					
	the toilet"						
	The facility's 12/	15/14 investigation					
		interdisciplinary team)					
	,	ed the different ways to					
		are falls such as seat belt					
		nd bed alarm to alert staff					
		ng out of bed or chair					
	without assistance						
		from ER physician to					
		(Physical Therapy) apt.					
	(appointment)."						
		icated the facility's					
	_	ed to address/put in					
	_	measures to protect					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G447	B. WIN			01/21/	2015
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
VOCA C		INIDIANIA			NOLLTON RD APOLIS, IN 46228		
	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46226		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
IAG		tential falls in the		IAG	,		DATE
	bathroom and/or						
	bathroom and/or injuries.						
	Interview with Clinical Supervisor (CS)						
	#1, the QIDP and LPN #1 on 1/14/15 at						
		ed client C's IDT met and					
	reviewed the fall						
		ns. LPN #1 and the QIDP					
		C was to see the PT on					
	1/15/15. The QI						
	-	T's recommendations to					
		t and wheelchair/bed					
		een purchased as they					
		client C's PT (physical					
	_	ion to be completed. The					
		#1 indicated facility staff					
	-	he bathroom with client					
		bathing and being					
		nt the client from falling.					
	•	.PN #1 indicated client					
		plan and/or record did					
	-	facility staff were to					
		when in the bathroom to					
		I falls and/or injuries.					
	prevent potential	i ians and/or injuries.					
	This deficiency	was cited on 11/12/14.					
	_	ed to implement a					
		correction to prevent					
	recurrence.	correction to prevent					
	rocurrence.						
	9-3-2(a)						
) 5 2(u)						
W000240	483.440(c)(6)(i)						
	INDIVIDUAL PRO	OGRAM PLAN					

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STATEMEN	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	∧ ріп	LDING	00	COMPLET	TED	
	15G447		A. BUI B. WIN			01/21/20	015	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIE	R			NOLLTON RD			
VOCA C	ORPORATION OF	INDIANA			IAPOLIS, IN 46228			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		ogram plan must describe						
	individual toward	ions to support the						
		iew and record review for	$ _{\mathbf{w}_0}$	00240		1	02/20/2015	
		clients (C), the client's	""	00210	CORRECTION:	'	02/20/2013	
	•	ort Plan (ISP) failed to			The individual program plan			
					must describe relevant			
		cility staff were to			interventions to support the			
		se the client, when in the			individual toward			
	bathroom, to pre	event falls/injuries.			independence. Specifically, the			
					facility nurse will modify Client (
	Findings include	e:			Comprehensive High Risk Plan f falls to clarify the expectations f			
					"stand by" assistance while Clien			
	The facility's rep	portable incident reports,			C is in the bathroom including b			
	the facility's into	ernal Incident/Accident			not limited to hands on use of a			
	Reports (IARs)	and/or investigations			gait belt at all times while client	С		
	were reviewed o	on 1/14/15 at 11:17 AM.			is toileting and showering. The			
	The facility's re	portable incident reports,			team will also provide a modifie	d		
		restigations indicated the			toilet seat with side rails.			
	following (not a	•			Additional modifications may be made after Client C's scheduled			
					Occupational Therapy			
	-11/11/14 "Upo	n arrival to group home			appointment. A review of incide	nt		
		ndividual Supported by			documentation and current risk			
		st been assisted off the			plans indicated this deficient			
	'				practice did not affect any			
		group home by staff. As			additional clients.			
		ied to assist the other						
		he van (sic) [client C]			PREVENTION:			
		into the bathroom			PKEVENIIUN:			
		someone to assist her.			The QIDP will assure that the			
	While [client C]	was in the bathroom she			nursing team is included in all			
	proceeded to tak	ce off her brief and pants			discussions/decisions relevant to			
	causing her to fa	all to her knees causing an			clients' health and safety and			
	(sic) half inch ir	n diameter injury to the			modifications will be made to			
	` ′	area was cleaned with			Comprehensive High Risk Plans			
	-	ntment applied to the area			accordingly. The nurse manager			
	peroxide and on	applied to the titel			will review all reports of			

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPLI	ETED
		15G447	A. BUI B. WIN			01/21/	2015
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R			NOLLTON RD		
VOCA C	ORPORATION OF	INDIANA			APOLIS, IN 46228		
	_			INDIAN	AFOLIS, IN 40220		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and covered wit	h bandaide (sic)[Client			significant health and safety		
	C] has a high ris	sk plan for falls in place			issues and will meet with the		
	and staff will co	ntinue to implement her			Operations Team weekly to		
		er moral support. The			discuss health and safety issues		
		team will be meeting to			including but not limited to		
		•			needed updates to risk plans. Th	ie	
		ways to ensure [client			nurse manager will review all		
	C's] safety."				facility risk plan modifications for		
					the next 90 days to assure they contain appropriate detail, and		
	-12/12/14 "As I	(staff #5) brushed [client			will conduct periodic audits of		
	C's] head she wa	as complaining of pain on			facility risk plans on an ongoing		
	her head where	I brushed. I asked her			basis.		
		g (sic) she stated that she			54515.		
	_						
		o off the toilet and hit her					
		et seat." The IAR			RESPONSIBLE PARTIES:		
	indicated "The	ere is a scratch that is a			QIDP, Residential Manager,		
	(sic) inch long it	t is red and sore to the			Team Leader, Health Services	3	
	touch (sic)."				Team, Direct Support Staff,		
	l , , ,				Operations Team		
	The facility's 12	/31/14 follow-up report					
	_	reportable incident report					
		•					
	_	nt C's] injury has healed					
		nedical treatment was					
	needed. In doin	g the investigation it was					
	reported from th	e staff that worked that					
	evening [client (C] was assisted to the					
		er bed with no injuries					
		vening. [Client C]					
	_						
		at she had fell and could					
		hen she fell. Staff are					
	-	on [client C's] high risk					
	plan for falls and	d will monitor [client C]					
	more closely."						
	_						
	-12/15/14 "Staff	was assisting [client C]					
l	12/13/17 Stall	was assisting [chefit C]	ı				

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION		A. BUILDING 00			COMPL	
		15G447	B. WIN			01/21/	2015
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
VOCA CO	ORPORATION OF I	NDIANA			NOLLTON RD APOLIS, IN 46228		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		orted by ResCare) with					
	using the toilet.	Staff turned to the side					
	to rinse a washcl	oth and [client C] fell off					
	the commode an	d hit her head resulting					
	in a 1/2 (one half	f inch) laceration. Staff					
	called 911 and E	MS (Emergency Medical					
	Services) transpo	orted [client C] to the					
	[name of hospita	l] for evaluation and					
	treatment via am	bulance. ER (emergency					
	room) personnel	closed and dressed the					
	injury and releas	ed [client C] to ResCare					
	staff with wound	care instructions.					
	[Client C] is rest	ing comfortably at home					
	and staff will per	form neuro					
	(neurological) ch	necks for 24 hours per					
	protocol. [Client	t C] has a history of falls					
	and a Comprehe	nsive High Risk Plan is					
	in place, the risk	plan for falls directs					
	staff to provide h	ner with stand-by					
	assistance while	transferring to and from					
	the toilet"						
	Client Clarecard	was reviewed on					
		PM. Client C's 5/13/14					
		Addendum indicated					
		nsteady gait. The					
		ated "In the past, [client					
		al injuries as a result of					
		client C] currently					
		hairEven though					
		s a wheelchair, she still					
	•	ire prompting to use it					
		uires assistance to move					
	into seats from h	er wheelchair"					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	A. BUILDI B. WING	NG	NSTRUCTION 00	(X3) DATE COMPL 01/21 /	ETED	
	PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
	Plan (ISP) indice does not utilize ambulating her or several redirective belt is fasten (six continue this gowheelchair in an [Client C] is still in asking for assistant require her wheelchairIn the been noted as far move out of her Client C's undat High Risk Health used a wheelchair isk plan indicated hands-on assistant exiting the vanustandby assistant ambulation exert at least standby showering/bathic Client C's record ResCare's undat PREVENTION client's record.	a appropriate manner). 4.) I having slight problems sistance in doing things to get out of her the past, [client C] has lling when trying to wheelchair." ed Decreased Mobility the Plan indicated client C that for all mobility. The ed "4. Staff to provide the entering and some of the provide ce during in home cises. 6. Staff to provide assistance during mg/toileting" d indicated client C had ed policy titled FALL PROTOCOL in the The undated policy fCY: Falls occur among						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	E SURVEY PLETED 1/2015
	PROVIDER OR SUPPLIER		4114 KI	ADDRESS, CITY, STATE, ZIP CO NOLLTON RD APOLIS, IN 46228	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	disoriented. The fall risk assessme individuals requi prevent falls. Th	e data obtained from the ent will identify which ire special measures to be risk for falls can be ral factors as outlined				
	Staff should orient the person to the environment.					
	2. Staff should prototograms footwear, mats a					
	3. Adequate ligh	nting in the environment.				
	4. Close supervi	sion, when applicable.				
	5. Place beds in position as defin	lowest appropriate ed by the IDT.				
	6. Side rails up	if applicable.				
	7. Provide ambu applicable.	ılatory aids, when				
	8. Assess medic increase risk of f	ations administered that alling.				
	9. Should fall or nurse immediate	eeur staff will notify ly				

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447		A. BUI	LDING	00	COMPL	
		15G447	B. WIN	IG		01/21/	2015
NAME OF B	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			4114 KN	NOLLTON RD		
VOCA CO	ORPORATION OF I	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	13. IDT will me						
	individualized fall prevention per ISP/BSP (Behavior Support Plan) or						
	other safety protocols, when applicable."						
	Client C's record	l indicated the following					
		tes (not all inclusive):					
		,					
		C's IDT met to follow up					
		visit. The IDT note					
		6/14 "[Client C] fell					
	out (sic) the bed	getting out without					
	asking for assista	ance. The team decided					
	to put her wheel	chair away from her bed					
	so she can call fo	or help. Staff also have					
		ousemate not to try to					
	help without staf						
	Trop without star	a wood ware on the control of the co					
	-11/19/14 "[Cl	ient C] fell in the					
	bathroom trying	to toilet herself					
	independently.	Staff will push [client C]					
		as soon as she gets off					
		st her to prevent future					
	falls."	F					
	Twing.						
	-12/15/14 "12/12	2/14 - [Client C] had a					
	scratch on her he	ead that was noticed by					
		were brushing her hair.					
		he fell. [Client C] is					
	-	rself off the floor so an					
	_	being conducted to					
	determine what l						
	-	nt C] fell off the toilet					
	while completing	g her ADL's (Adult Daily					

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPL 01/21/	ETED
NAME O	F PROVIDER OR SUPPLIEF	\ \		STREET A	DDRESS, CITY, STATE, ZIP CODE		
VOCA	CORPORATION OF	INDIANA		INDIANA	APOLIS, IN 46228		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE .	(X5) COMPLETION DATE
	wash out the fact some how lost be toilet. Staff assist floor. [Client Control of the control of	staff said she turned to e towel and [client C] alance and fell off the sted [client C] off the had a gash on her vas taken to ER where and released. As a od [client C] needs a seat elchair. The team also c C] having her gait belt her and the safety bars he toilet to prevent her C] would also benefit chair alarm to alert staff ing to get out the chair (sic). If any of these hire HRC (Human Rights oval it will be obtained reviewed by the mmittee." Client C's d IDT notes and/or record fility failed to specifically fility staff were to se client C while in the went potential falls and/or erview A stated client C past, but had "no falls ential interview A were to be in the bathroom hen she was in the fidential interview A estand on her own."					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G447	B. WIN	G		01/21/2	2015
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
V004 00		INITHANIA			NOLLTON RD		
	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORT OR	ESC IDENTIFY THOU INFORMATION)		IAG			DATE
	Confidential inte	erview B stated when					
	asked how client						
	supervised/monitored in the bathroom, "Help her in there. Help on commode.						
	_	down and hold onto gait					
		out and then she calls us					
		e go back in there and					
		hold onto gait belt."					
		erview B indicated client					
		to the safety bar in the					
		•					
		l. When asked how					
		II, confidential interview					
		at much. She will jump					
	•	nair unlocked and fall.					
	We hear hollerin	ng and find her on floor."					
	Interview with s	taff #4 on 1/14/15 at 7:35					
		ient C fell last month.					
		staff was giving the					
		off. Turned to rinse					
		She (client C) fell on					
		ked if client C had fallen					
		ore, staff #4 stated "Quite					
		not fallen on my shift."					
	,	,					
	Interview with C	Clinical Supervisor (CS)					
		d LPN #1 on 1/14/15 at					
		ed client C was a fall					
		and LPN #1 indicated					
		e to stay in the bathroom					
		en she was bathing and					
		prevent the client from					
	_	OP and LPN #1 indicated					
	.wg. 1110 Q11	21 and Diff ii indicated					

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G447	B. WIN			01/21/	2015
NAME OF P	ROVIDER OR SUPPLIER		p		ADDRESS, CITY, STATE, ZIP CODE		
					NOLLTON RD		
VOCA CO	DRPORATION OF I	NDIANA		INDIAN.	APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL I SC IDENTIFYING INFORMATION)		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓΕ	COMPLETION
W000263	client C's mobility did not indicate I monitor client C prevent potential 9-3-4(a) 483.440(f)(3)(ii) PROGRAM MONITHE committee ship programs are concentrated informed comparents (if the client guardian. Based on intervice 2 of 4 sampled comparents in clients legally appresentative program obtain written in clients' legally appresentatives/g Care Representatives/g December 2014 indicated client C milligrams 2 table Depression and Z for Schizoaffectives/g Client C's 5/13/1 (BAP) indicated	ty risk plan and/or record how facility staff were to when in the bathroom to a falls and/or injuries. TORING & CHANGE ould insure that these ducted only with the consent of the client, in the saminor) or legal ew and record review for lients (B and C) with ams, the facility failed to formed consent from the oppointed guardians and/or Health tives (HCR). TORING & CHANGE ould insure that these ducted only with the onsent of the client, in the consent of the client, in the consent of the client of the	Wo	00263	CROSS-REFERENCED TO THE APPROPRIAT	<i>at</i>	02/20/2015
	` '	n, physical aggression,					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		15G447	B. WIN			01/21/2015	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	NOLLTON RD		
	ORPORATION OF			INDIAN	IAPOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		i
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE	
		havior (SIB), crying and			DDEVENTION:		
		tion. Client C's 5/13/14			PREVENTION:		
	BAP indicated f	acility staff could utilize			When guardians and healthcare		
	"Protective Rest	raint" of having client C			representatives are unable to		
	place her hands	in her protective			attend team meetings face to		
	mittens/gloves when the client continued				face, consent forms will be sent		
	her targeted beha				via postal mail for review and		
	3				signature, along with a stamped		
	Client C's 5/13/1	4 Individual Support			envelope addressed to the		
		ated client C's brother			facility. If consents are not		
	` ′				returned to the facility in a timel		
		HCR. Client C's 5/13/14			manner via standard postal mail	,	
		did not indicate the			the QIDP will send the forms to the appropriate legal		
	_	written informed			representative via registered ma	il	
	consent for the c	elient's restrictive			to assure the documents have	"	
	program.				been delivered and received.		
					Members of the Operations Tear	n	
	2. Client B's rec	ord was reviewed on			will review restrictive programs		
	1/14/15 at 2:33 I	PM. Client B's 12/1/14			on an ongoing basis to assure		
		rs indicated client B			prior written informed consent		
		20 milligrams three			has been obtained. Initially		
		cote DR 500 milligrams			administrative monitoring will		
	_	_			occur with increased frequency	as	
		for Attention Deficit			follows: Members of the Operations Team and the QIDP		
		isorder. Client B's			will conduct active treatment		
	1 2	rs indicated client B			observations and documentation	,	
		on 45 milligrams at			reviews no less than five times		
	bedtime for Inso	mnia, Zyprexa 20			weekly for the next 21 days, no		
	milligrams at be	dtime for behaviors and			less than 3 times weekly for an		
	Invega intramus	cular injection every 4			additional 14 Days, and no less		
	weeks for behav	ior.			than twice weekly for an		
					additional 60 Days. At the		
	Client B's 8/14/1	4 BAP indicated client B			conclusion of this period of		
		ysical aggression,			intensive administrative		
	_				monitoring and support, the		
		in the face and SIB.			Operations Team will determine		
	Client B's BAP	indicated client B was to			the level of ongoing support		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	ETED
		15G447	B. WIN			01/21/	2015
NAME OF B	DROWNER OF GUIDNI IED		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			4114 KI	NOLLTON RD		
VOCA CO	ORPORATION OF I	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	·		DATE
		f sight during waking			needed at the facility.		
		client was not in her					
		t B's BAP indicated this					
		que was being utilized			RESPONSIBLE PARTIES:		
		s behaviors. Client B's					
	8/14/14 BAP ind	licated physical			QIDP, Residential Manager, Tear	n	
	redirection could	l be utilized by staff			Leader, Direct Support Staff,		
	when client B be	ecame aggressive toward			Operations Team		
	others.						
	Client B's 8/14/1	4 ISP indicated client					
	B's mother was t	he client's guardian.					
	Client B's ISP ar	nd/or BAP did not					
	indicate client B	's guardian gave written					
	informed consen	-					
	restrictive progra	am.					
	1 2						
	Interview with th	ne Qualified Intellectual					
	Disabilities Prof	essional (QIDP) and					
	Clinical Supervis	sor #1 on 1/14/15 at 3:35					
	PM indicated the	e QIDP had sent clients B					
		re plans to their guardian					
		e QIDP indicated she					
		clients B and C's					
	guardian and/or	HCR written informed					
	consent sheets ba						
	This deficiency	was cited on 11/12/14.					
	1	ed to implement a					
	1	correction to prevent					
	recurrence.	1					
	recurrence.						
	9-3-4(a)						
			- 1				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447			A. BUILDING 00			COMPL	3) DATE SURVEY COMPLETED 01/21/2015	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
W000331	services in accord Based on observice or review for (A and C), the far failed to meet the clients in regard revising risk plansignificant change and/or document information of comparison of comparis	rovide clients with nursing ance with their needs. ation, interview and r 2 of 4 sampled clients willity's nursing services enursing needs of the to developing and/or as, addressing a client's ge in weight (weight loss) sing pertinent health lients. 13/15 observation period of and 6:45 PM, at the ent A was small in the 1/13/15 observation refused to eat dinner. offered the client a the client refused. Then offered the client A ed pineapple. Client A deat the pineapple. Ot the bowl of pineapple, to eat the pineapple and soom before returning to	Woo	00331	CORRECTION: The facility must provide clients with nursing services in accordance with their needs. Specifically for Client A, the facility nurse will contact the dietician to collaborate on enhancements to Client A's comprehensive High Risk Plan for Weight Loss. Additionally the interdisciplinary team will modify Client A's Behavior Support Plan to include proactive and reactive strategies to address meal refusals. Specifically for Client C, the facility nurse will modify Client C Comprehensive High Risk Plan for falls to clarify the expectations for "stand by" assistance while Client C is in the bathroom including but not limited to hands on use of a gait belt at all times while client is toileting and showering. The team will also provide a modifications may be made after Client C's scheduled.	s's or or or ot ut	02/20/2015	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	LDING	00	COMPL	ETED
		15G447	B. WIN			01/21/	2015
		l .	b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			NOLLTON RD		
VOCA C	ORPORATION OF	ΙΝΠΙΔΝΔ			APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	·		DATE
		ent A refused to eat			Occupational Therapy		
	breakfast. Facility staff did not offer the				appointment. A review of incider	it	
	client an alternat	te meal/food to eat.			documentation and current risk		
					plans indicated this deficient		
	Client A's record	d was reviewed on			practice did not affect any additional clients.		
	1/14/15 at 12:30				additional chemis.		
		physician's orders					
		A's diagnoses included,			PREVENTION:		
		ited to Diabetes Mellitus					
	and Anemia. Cl	ient A's December 2014			The QIDP will assure that the		
	physician's order	rs indicated facility staff			nursing team is included in all		
	should encourag	e "lower cholesterol			discussions/decisions relevant to		
	snacks." The ph	ysician's orders also			clients' health and safety and		
	_	second servings of meat			modifications will be made to		
		ave snack/sandwich			Comprehensive High Risk Plans		
	1	luding during the night			accordingly. The nurse manager		
					will review all reports of significant health and safety		
	_	ss." The December 2014			issues and will meet with the		
		indicated client A			Operations Team weekly to		
	should have 1 ca	nn of Glucerna 4 times a			discuss health and safety issues		
	day as a nutrition	nal supplement and a			including but not limited to		
	Glucerna bar at l	lunch and at bedtime for			needed updates to risk plans. Th	e	
	a nutritional sup	plement.			nurse manager will review all		
	•	•			facility risk plan modifications for	-	
	Client A's Nove	mber 2014 Nurse Notes			the next 90 days to assure they		
		the record) indicated			contain appropriate detail, and		
	`	,			will conduct periodic audits of		
		d 83 pounds 1 month ago,			facility risk plans on an ongoing		
	-	onths ago and 100			basis.		
		go. The 11/14 nurse note					
	did not have a cu	arrent weight for client					
	A. The area for	the "Current Weight"			RESPONSIBLE PARTIES:		
	was blank. The	nurse note indicated			ALSI GROIDLE FARIILS.		
		oody weight range was			QIDP, Residential Manager, Tear	n	
		nds and 101 pounds.			Leader, Health Services Team,		
	between 65 pour	ids and 101 pounds.			Direct Support Staff, Operations		
	I		1		1 7 2 2 7 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G447	B. WING		01/21/2015
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				(NOLLTON RD	
VOCA CO	ORPORATION OF I	INUIANA	INDIAN	NAPOLIS, IN 46228	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	<u> </u>	DATE
	Client A's 10/30	•		Team	
		ment indicated the			
	following weigh	ts for client A:			
	-9/13 100 pound				
	-10/13 100 poun				
	-11/13 100 poun				
	-12/13 95 pound	S			
	-1/14 98 pounds				
	-2/14 100 pound				
	-3/14 96.6 pound	ls			
	-4/14 95 pounds				
	-5/14 100 pound	S			
	-6/14 96 pounds				
	-7/14 "?" (questi	on) no weight			
	documented				
	-8/14 95 pounds				
	9/14 "?" no weig	ght documented. The			
	10/30/14 assessn	nent indicated client A's			
	current weight at	t the time of the			
	assessment was	83 pounds. The			
	assessment indic	ated "Weight down			
	likely d/t (due to) scale change but			
		ody Mass Index) is			
	low/below the re	ec. (recommended) range.			
		s Glucerna supplement			
		lay) for additional			
	` `	weight as evidenced by			
		n) 18.5Goal -Weight			
	`	ounds) x (times) 3			
		te rec. range (18.5-24.9).			
		diet orders (with)			
	` ′	Offer snacks between			
	meals and HS (b				
	incais and 113 (0	cdiffic) shack.			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	00	(X3) DATE COMPL		
		15G447		LDING		01/21/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				NOLLTON RD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	 Client A's 12/7/1	4 Individual Support					
		ated client A did not have					
	` ′	n addressed the client's					
	_	er record. Client A's ISP					
		Behavior Action Plan					
		ddress the client's refusals					
	` ′	licate how/what the					
	· · · · · · · · · · · · · · · · · · ·	e to do to get client A to					
	eat.	-					
	Interview with L	PN #1 and the Qualified					
	Intellectual Disa	bilities Professional					
	/	15 at 3:35 PM indicated					
		efuse to eat. LPN #1					
		A's current weight was 85					
		31/14. LPN #1 stated					
		0 pound weight loss" in					
		PN #1 stated the weight					
	1	ficant loss" for client A.					
		d she had not addressed					
	the client's weigh						
		A had a supplement drink lient was to receive if the					
		and/or finfish her meal.					
		QIDP indicated facility					
		p prompting the client to					
	_	used to eat. The QIDP					
		A would not eat to get the					
		ink as the client liked the					
		P and LPN #1 indicated					
	1	d not indicate what					
		e to do when client A					
	1 -	nd/or indicate how					
							l

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Event ID:

18FZ12

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G447	A. BUI	LDING	00	COMPL 01/21/	
		130447	B. WIN		PPPPGG GYPY GT AT GOD	01/21/	2015
NAME OF P	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD		
VOCA CO	ORPORATION OF	INDIANA			APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)		TAG	BETTELLINETY		DATE
	lacility stall wel	re to assist client A to eat.					
	2 The facility's	reportable incident					
	reports, the facil	-					
		nt Reports (IARs) and/or					
		ere reviewed on 1/14/15					
	_	he facility's reportable					
	incident reports,						
		dicated the following					
	(not all inclusive						
	(1100 W11 11101W51)	·)·					
	 -11/11/14 "Upor	arrival to group home					
	•	dividual Supported by					
		t been assisted off the					
		group home by staff. As					
		ed to assist the other					
		he van (sic) [client C]					
		into the bathroom					
	without asking s	omeone to assist her.					
		was in the bathroom she					
	proceeded to tak	e off her brief and pants					
	causing her to fa	ll to her knees causing an					
	(sic) half inch in	diameter injury to the					
	right knee. The	area was cleaned with					
	peroxide and oir	ntment applied to the area					
	and covered with	h bandaide (sic)[Client					
	C] has a high ris	k plan for falls in place					
	and staff will co	ntinue to implement her					
	plan and give he	r moral support. The					
		team will be meeting to					
		ways to ensure [client					
	C's] safety."						
	-12/12/14 "As I	(staff #5) brushed [client					

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Facility ID: 000961

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G447	B. WIN			01/21/	2015
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
\/OCA C/	ORPORATION OF I	NIDIANIA			NOLLTON RD		
	ORPORATION OF I	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
TAG		,	+	IAU			DATE
	C's] head she was complaining of pain on her head where I brushed. I asked her						
	_	(sic) she stated that she					
		off the toilet and hit her t seat." The IAR					
		re is a scratch that is a					
		is red and sore to the					
	touch (sic)."						
	The facility's 12	31/14 follow-up report					
	1	eportable incident report					
		at C's] injury has healed					
	_	edical treatment was					
		g the investigation it was					
		e staff that worked that					
	•	C] was assisted to the					
		er bed with no injuries					
		vening. [Client C]					
		at she had fell (sic) and					
		iber when she fell. Staff					
	_	ed on [client C's] high					
	-	s and will monitor [client					
	C] more closely.						
	10/15/14 1104 - 00	was assisting [slicht C]					
		was assisting [client C]					
	`	orted by ResCare) with					
	_	Staff turned to the side					
		oth and [client C] fell off					
		d hit her head resulting					
	· `	f inch) laceration. Staff					
		MS (Emergency Medical					
		orted [client C] to the					
	_	l] for evaluation and					
	treatment via am	bulance. ER (emergency					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE COMPL		
11112 12111	or confidence.	15G447		LDING		01/21/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				NOLLTON RD		
VOCA C	ORPORATION OF I	NDIANA			APOLIS, IN 46228		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		closed and dressed the	+	TAG	BH IOLINO 1		DATE
	· •	ed [client C] to ResCare					
		care instructions.					
		ing comfortably at home					
	and staff will per						
	•	necks for 24 hours per					
		t C] has a history of falls					
		nsive High Risk Plan is					
	•	plan for falls directs					
	staff to provide h	-					
	-	transferring to and from					
	the toilet"	C					
	An attached 12/1	5/14 Progress Note to					
	the facility's 12/1	15/14 investigation					
	indicated "[Clien	nt C] had Nasty fall in the					
	bathroom this Al	M, while being assist					
	(sic) by staff men	mber. Slid down off					
	toilet as staff was	s trying to wash her.					
	[Client C] fell fo	rward and hit her head.					
		l and she stated to call					
	emerg. (emergen	cy). She was then taken					
	• • •	al) for observation." The					
		gation indicated "IDT					
	(interdisciplinary	· · · · · · · · · · · · · · · · · · ·					
		ferent ways to help					
	*	lls such as seat belt for					
		ped alarm to alert staff					
		ng out of bed or chair					
	without assistance						
		from ER physician to					
		(Physical Therapy) apt.					
	(appointment)."						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G447	B. WIN			01/21/2015
NAME OF F	PROVIDER OR SUPPLIER	-		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					NOLLTON RD	
VOCA C	ORPORATION OF I	NDIANA		INDIAN	APOLIS, IN 46228	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		was reviewed on				
		PM. Client C's 12/15/14				
		(ROV) indicated client C				
		al hospital due to a fall.				
		ted client C had a				
		tion. Normal head CT				
		rvical spine CT. Keep				
		4 hours then wash as				
		r signs of infection.				
	Recommend PT	for strengthening and				
	fall prevention."					
	Client C's 12/12/	14 ROV indicated client				
	C was seen at EI	R due to a fall. The ROV				
	indicated "Fronta	al Forehead bruising &				
	(and) Abrasion.	Forehead				
	contusion/Abras	ion. Head Injury				
	instructions. Ty	lenol for pain."				
	-	•				
	Client C's 12/15/	14 nurse note indicated				
	the facility's nurs	se went to the group				
	home to assess c	lient C after she returned				
	from the ER. Th	ne nurse note indicated				
		tched facility staff				
		t from the wheelchair to				
		the wheelchair to the				
		a gait belt and pivot to				
	_	ansfer. The nurse note				
		sumer had a folded up				
		overing the wound on				
		_				
	forehead from fall, secured with transparent medical tape. Staff reported					
	-	ER, the doctor there				
		substance to close the				
	useu a giue-iike	substance to close the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
11112 12111	or condition,	15G447		LDING		01/21/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				NOLLTON RD		
VOCA C	ORPORATION OF I	NDIANA			APOLIS, IN 46228		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		Staff also reported that		TAG	BEHREIMET		DATE
	_	id advised not to cleanse					
		next day. The size of					
		pprox. (approximately) 1					
		Consumer was present					
	_	neeting, and it was					
	_	the 'scoots' herself around					
		r, but she leans forward					
		s." Client C's nurse					
		ord indicated the facility's					
		ocument when and/or if a					
		nd been set up/scheduled.					
	1 1 evaluation no	a been set up/seneduled.					
	Client C's 5/13/1	4 Health Supports					
	Addendum indic	ated client C has an					
	unsteady gait. T	he addendum indicated					
	"In the past, [c	lient C] has had several					
	injuries as a resu	lt of falls; therefore					
	[client C] curren	tly utilizes a					
	wheelchairEve	n though [client C]					
	utilizes a wheelc	hair, she still continues					
		ting to use it properly					
	_	stance to move into seats					
		hairShe will continue					
	to have a PT eva	luation annually"					
	Client C's 5/13/1	4 Individual Support					
		nted "3.) [Client C]					
	, ,	proper precautions when					
	_	vheelchair, despite staff					
	prompting her of	therwise. She needs					
		ons to make sure her seat					
	belt is fasten, the	team agreed to continue					
	this goal (to utili	ze her wheelchair in an					

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SI	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	TED
		15G447	B. WIN		-	01/21/2	015
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				NOLLTON RD		
VOCA CO	ORPORATION OF I	NDIANA			APOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re I	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	appropriate mani	ner). 4.) [Client C] is still					
	having slight pro	blems in asking for					
	assistance in doi	ng things that require her					
		wheelchairIn the past,					
	_	en noted as falling when					
		ut of her wheelchair."					
	l a ying to move o	at of fice wifecienan.					
	Client Claundate	ed Decreased Mobility					
		h Plan indicated client C					
		ir for all mobility. The					
	_	ed "4. Staff to provide					
		nce when entering and					
	_	5. Staff to provide					
	standby assistand	ce during in home					
	ambulation exerc	cises. 6. Staff to provide					
	at least standby a	assistance during					
	showering/bathing	ng/toileting. 7. Should					
	fall occur NOTII	FY the nurse					
	immediately"						
	Client C's record	indicated client C had					
	ResCare's undate	ed policy titled FALL					
		PROTOCOL in the					
		The undated policy					
		CY: Falls occur among					
	people who are v	•					
		_					
	-	aralyzed, confused or					
		data obtained from the					
		ent will identify which					
	_	ire special measures to					
	•	ne risk for falls can be					
	reduced by sever	ral factors as outlined					
	below.						

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		15G447	B. WIN			01/21/	2015
			_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			NOLLTON RD		
VOCA CO	ORPORATION OF	INDIANA			APOLIS, IN 46228		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	PROCEDURE:						
	1. Staff should orient the person to the environment.						
	Cirvironinient.						
	2 9 9 1 11	11 111					
	2. Staff should p						
	footwear, mats a	and rugs.					
	3. Adequate ligh	hting in the environment.					
	4 Close supervi	ision, when applicable.					
	01000 50.p01	more, when approved.					
	5 Dlaga bada in	lavvast ammunista					
		lowest appropriate					
	position as defin	ed by the IDT.					
	6. Side rails up	if applicable.					
	7. Provide ambu	ulatory aids, when					
	applicable.						
	Q Aggag madia	eations administered that					
	increase risk of f	falling.					
	9. Should fall of	ccur staff will notify					
	nurse immediate	ely					
	13. IDT will me	eet to discuss					
		all prevention per					
		• •					
	· ·	rior Support Plan) or					
	other safety prot	ocols, when applicable."					
	Client C's record	l indicated the following					
	IDT Meeting no	tes (not all inclusive):					
	_	•					

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Event ID:

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDIN		LDING 00		COMPLETED	
		15G447	B. WIN	G		01/21/	2015	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
					NOLLTON RD			
VOCA CO	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46228			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE		
IAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE	
		C's IDT met to follow up						
		visit. The IDT note						
	indicated on 7/26/14 "[Client C] fell							
	out (sic) the bed getting out without							
	_	ance. The team decided						
	_	chair away from her bed						
		or help. Staff also have						
		ousemate not to try to						
	help without stat	T assistance"						
	11/10/14 !! [CI	in a Cl Call in the						
	-11/19/14 "[Client C] fell in the							
	bathroom trying to toilet herself							
		Staff will push [client C]						
	to the bathroom as soon as she gets off							
	the van and assist her to prevent future							
	falls."							
	12/15/14 #12/12	0/14 [Client Client e						
		2/14 - [Client C] had a						
	scratch on her head that was noticed by							
	staff when they were brushing her hair.							
	[Client C] said she fell. [Client C] is							
	unable to get herself off the floor so an							
	investigation is being conducted to							
	determine what happened12/15/14- [Client C] fell off the toilet							
	-	-						
	1 .	g her ADL's (Adult Daily						
		taff said she turned to						
		e towel and [client C]						
		alance and fell off the						
		sted [client C] off the						
		had a gash on her						
		as taken to ER where						
	she was treated and released. As a							
	prevention method [client C] needs a seat							

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	OF CORRECTION IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/21/2015			
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN 46228					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION			
	belt for her wheelchair. The team also discussed [client C] having her gait belt secured around her and the safety bars when she is on the toilet to prevent her falling. [Client C] would also benefit from a bed and chair alarm to alert staff when she is trying to get out the chair with assistance (sic). If any of these suggestions require HRC (Human Rights Committee approval it will be obtained after this plan is reviewed by the management committee." Client C's above mentioned IDT meeting notes, ISP and/or record indicated the facility's nursing services failed to develop a specific risk plan in regard to client C's falls which indicated how facility staff were to monitor/supervise client C while in the bathroom to prevent potential falls and/or injuries. Confidential interview A stated client C had fallen in the past, but had "no falls lately." Confidential interview A indicated staff were to be in the bathroom with client C when she was in the bathroom. Confidential interview A stated "She can't stand on her own." Confidential interview B stated when asked how client C was to be supervised/monitored in the bathroom, "Help her in there. Help on commode. Maneuver to sit down and hold onto gait						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	a. building 00		00	COMPLETED	
15G447		B. WIN	B. WING			01/21/2015	
NAME OF I	PROVIDER OR SUPPLIER	R		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					NOLLTON RD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46228		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAG	belt. We come out and then she calls us			IAG	,		DATE
	when ready. We go back in there and						
	<u> </u>	_					
	help her up and hold onto gait belt." Confidential interview B indicated client						
		n to the safety bar in the					
	bathroom as wel						
	outin com us we	•••					
	Interview with s	staff #4 on 1/14/15 at 7:35					
		ient C fell last month.					
		staff was giving the					
		off. Turned to rinse					
	wash cloth off. She (client C) fell on						
	floor." When asked if client C had fallen						
	on the floor before, staff #4 stated "Quite						
	a few times, but not fallen on my shift."						
	Interview with C	Clinical Supervisor (CS)					
	#1, the QIDP an	d LPN #1 on 1/14/15 at					
	3:35 PM indicated client C was a fall						
	risk. When aske	ed how the client fell off					
	the toilet, the QI	IDP stated "She leaned					
		." The QIDP indicated					
		net and reviewed the falls					
		nmendations. LPN #1					
	and the QIDP in	dicated client C was to					
		15/15. The QIDP and					
	LPN #1 indicate						
		ns to obtain a seat belt					
		bed alarms had not been					
	_	ey were waiting on the PT					
		completed. The QIDP					
		icated facility staff were					
	to stay in the bathroom with client C						
	when she was bathing and being toileted						

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STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN OF CORRECTION IE		IDENTIFICATION NUMBER:	A. BUILD	INIC	00	COMPL	ETED	
15G447		B. WING	ING	·	01/21/	2015		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				NOLLTON RD			
VOCA CORPORATION OF INDIANA			INDIANAPOLIS, IN 46228					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX			PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	to prevent the cli	ent from falling. When						
	asked if client C'	s fall risk plan had been						
	updated, LPN sta	ated "No." The QIDP						
		cated client C's mobility						
		record did not indicate						
	•	f were to monitor client						
	•							
	C when in the bathroom to prevent							
	potential falls and/or injuries.							
	This deficiency was cited on 11/12/14.							
	The facility failed to implement a							
	systemic plan of correction to prevent							
	recurrence.	•						
	9-3-6(a)							
)-3 - 0(a)							
W009999								
			W009	999	This Standard was placed back	k in	02/20/2015	
					compliance during the PCR			
	1				survey. No correction is require	ed.		

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